



# Mountain States Administration FLEXIBLE SPENDING Reimbursement Request Form

Please complete all information applicable to your request.

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please print)

Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_

Change of Address: \_\_\_\_\_

1. Attach a copy of receipts, bills and applicable notifications of benefits to document each request.
2. This reimbursement request is for IRS eligible expense incurred during the current flex plan year.
3. This reimbursement request has not previously been reimbursed and is not eligible for reimbursement from an insurance carrier.
4. The reimbursement request must be submitted for reimbursement no later than 90 days from the end of the flex plan year. Claims received after the 90 days will not be considered for reimbursement.
5. Your request for reimbursement must include the following:
  - Name of Patient/Birth Date
  - Type of service/supply provided
  - Date of service/purchase
  - Payment for each service/supply
6. For dependent care, attach a copy of receipts or the bill.
  - Name of Provider/Tax ID # / Address must be included on all receipts or bills

### **Medical Reimbursement Expenses (Attach copy of receipts or bills)**

Request Total: \$ \_\_\_\_\_ Date(s) of service: from \_\_\_\_\_ to \_\_\_\_\_

### **Dependent Day Care Reimbursement Expense (Attach copy of receipts)**

Request Total: \$ \_\_\_\_\_ Date(s) of service: from \_\_\_\_\_ to \_\_\_\_\_

Dependent Care Provider: \_\_\_\_\_

Social Security/Tax ID Number of Provider: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

*I hereby certify that this reimbursement request meets the requirements of Section 213 of the Internal Revenue Code and was incurred during the Flex Plan Year. I also certify that these expenses are not eligible for reimbursement under any other health plan, and that I have not been reimbursed for these expenses. I also understand that it is my responsibility to keep documented records in order to verify reimbursements I might receive.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax reimbursement request forms to:**  
Mountain States Administration  
303-627-0798 fax

**Mail reimbursement request to:**  
Mountain States Administration  
13901 E. Exposition Avenue  
Aurora, CO 80012  
303-627-0759 866-766-8725

**Certificate of Qualifying Health Care Expenses** – By signing and submitting this Health Care Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet *all* of the following conditions.

- ▶ **Each Receipt for which you are submitting meets the definition of “Medical Care Expenses” meaning “expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in Code § 213(d) (including, for example, amounts for certain hospital, doctor and dental bills, and medicines and drugs, whether purchased by prescription or over-the-counter)...”**
  - An expense is for “medical care” only if it is “for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.” An expense is not for medical care if (a) it is used merely to benefit general health (e.g., most vitamins and dietary supplements fall into this category); or (b) it is cosmetic in nature, directed at improving appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease (unless the item is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury arising from an accident or trauma, or disfiguring disease).
  - Medicines and drugs must also meet some other special IRS rules. For example, they must be generally accepted as falling within the category of medicine or drugs, be legally procured and not be a cosmetic or toiletry. To be reimbursed for medicines and drugs, you will need to provide (a) third-party substantiation (i.e., from a medical practitioner, pharmacy, multi-service merchant, etc.) stating the name of the medicine or drug, the date that it was purchased and the amount of the expense, and (b) additional information specified on our medical reimbursement request form. You may also be asked to provide further evidence that the item is for medical care (e.g., a statement from a medical practitioner that the item treats a specific medical condition for you, your spouse or dependent or a more detailed certification by you).

**Certificate of Qualifying Dependent Care Expenses** - By signing and submitting this Dependent Care Reimbursement Request Form, you are certifying that expenses for which you request reimbursement meet *all* of the following conditions. Capitalized terms used in this Form have the meanings described in the Plan.

- ▶ **Each Dependent for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:**
  - a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
  - your Spouse or a person who is your Dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.
- ▶ The reimbursement will not exceed the balance in your DCAP Account. In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made for the Plan Year, would exceed the applicable statutory limit. Your applicable statutory limit is the smallest of the following amounts:
  - your earned income for the calendar year (after your Salary Reductions under the Plan);
  - the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of \$250 (\$500 if you have two or more Qualifying Individuals), for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
  - either \$5,000 or \$2,500 for the calendar year, depending on your marital and tax filing status.
- ▶ The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- ▶ The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: if your Spouse is not working or looking for work when the expenses are incurred, he or she must be a fulltime student or physically or mentally incapable of self-care.
- ▶ You (or you and your Spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a Qualifying Individual.
- ▶ The expenses are incurred for the care of a Qualifying Individual, or for household services attributable in part to the care of a Qualifying Individual.
- ▶ If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13 who is your Dependent under federal tax law; or (2) your Spouse or a person who is your Dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household.
- ▶ If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- ▶ The person who provided care was not your Spouse or a person for whom you are entitled to a personal exemption under Code § 151(c). If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- ▶ The expenses are not paid for services outside your household at a camp where the dependent stays overnight.