Flexible Spending Account (FSA) Claim Form

Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

1 Personal Information

Employee Name _____ Company Name _____

Street Address, City, State, Zip _____ ☐No ☐Yes Address Change?

Phone Number _____ Social Security Number _____

2 Dependent Care Expenses *(Dates of Service are required in order to process claim)*

	Date of Service Start Date	Date of Service End Date	Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
1						
2						
3						
4						

Total Dependent Care Expenses _____

3 Health Care Expenses

	Date of Service MM	DD	YY	Medical	Rx	Dental	Vision	Hospital	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount
1				☐	☐	☐	☐	☐	☐			
2				☐	☐	☐	☐	☐	☐			
3				☐	☐	☐	☐	☐	☐			
4				☐	☐	☐	☐	☐	☐			
5				☐	☐	☐	☐	☐	☐			
6				☐	☐	☐	☐	☐	☐			
7				☐	☐	☐	☐	☐	☐			
8				☐	☐	☐	☐	☐	☐			
9				☐	☐	☐	☐	☐	☐			

Total Health Care Expenses

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____

Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, P.O. Box 219393, Kansas City, MO 64121-9393
Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)