Limited Flexible Spending Account (LFSA) 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 detail each of the items summarized below
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Please allow 2 business days for daims to be processed

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

****Notice****

Claims submitted on this form are for Limited FSA expenses and may include the following: Dental and/or Vision. Please refer to your current SPD to determine which expenses apply.

1 Personal Information

Employee Name _____ Company Name _____

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

Phone Number _____ Social Security Number _____

2 Limited Health Care Expenses

	Date of Service MM	DD	YY	Dental	Vision	Person Receiving Service	Amount
1				☐	☐		
2				☐	☐		
3				☐	☐		
4				☐	☐		
5				☐	☐		
6				☐	☐		
7				☐	☐		
8				☐	☐		
9				☐	☐		
						Total Health Care Expenses	

3 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)