Northwest Group Services

Flexible Spending Account
Claim for Reimbursement

DEPENDENT CARE CLAIM FORM

Instructions

1. Before completing this form, make sure your expenses qualify for reimbursement.
2. You must submit all covered health care expenses to yours and/or your spouse's health insurance carrier before submitting for Flexible Spending Reimbursement.
3. NWGS cut off dates for claims submissions each month is the 10th & 25th and we process payments the next business day. Payments will be mailed sometime after the day we process.
4. Mail or Fax this form with receipts to the address or fax number below.

Personal Information - Please correct any information which is not accurate.
PLEASE NOTE IF THERE HAS BEEN A CHANGE IN YOUR ADDRESS

FSA _____ _____
Group Number Employer Name

_____ _____ _____
EE ID Your Last Name First Name M.I.

_____
Home Address

_____ _____
City State Zip Code Daytime Phone Number (please add)

Health Care Expenses - Please check the appropriate box(es) to identify the expenses you are submitting. Please make sure your submission shows the following **Actual Dates of Service, Service Rendered, and the Amount you had to pay out of pocket**.

[ ] Expenses covered by a benefit plan: You must first submit the expenses to your insurance company and if applicable, your spouse's insurance company. Attach a copy of all applicable Explanation of Benefits (EOB) to this form to service reimbursement for any expenses not covered.
[ ] HMO/DMO copayments: Attach a copy of the itemized bill indicating copayments.
[ ] Expenses not covered under any benefit plan: Attach a copy of the itemized bill showing the provider's name, date of service, services provided and the amount charged.
[ ] Orthodontia expenses: Attach your paid receipt or payment coupon.

Total Health Care charges being submitted for reimbursement: $_____

Dependent Care Expenses - Your dependent care provider must sign this form verifying charges incurred OR you must submit a receipt from the provider for services rendered. An expense is incurred when the service is provided, not when you pay for it.

Services must be provided during the plan year and must be incurred prior to reimbursement of your claim. If you prepay your provider, you may submit this form after the first date of service, but not more than 30 days before the last date of service. (For example, if the dates of service are 4/1 through 4/30, you should not sign the form and submit the claim prior to 4/1.)

Provider (print) _____ Dates of Service _____/_____/____ to _____/_____/_____

Total Dependent Care charges being submitted for reimbursement $ _____

I certify that the above listed charges have been incurred.

Signature of Provider _____ Date _____/_____/_____

IMPORTANT: You are required to provide the name, address and taxpayer identification number or social security number of your dependent care provider when you file your income tax return. If you are unable to provide this information, the deduction for the Dependent Care FSA may be denied by IRS.

Signature
I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. I have not been reimbursed for these expenses nor are the expenses reimbursable under any other health and/or dependent care assistance plan. I am not applying these expenses toward any federal or state income tax deduction or credit.

Your Signature _____
Date _____

Mail or Fax this form with receipts to:

N.W.G.S. (TPA Services)
8245 Farnsworth Road, Suite B
Waterville, Ohio 43566
Email: nwgsclaims@nwgsonline.com

Questions: 1-888-808-3008
Local Number: 419-887-1215
Fax Number: 419-887-1214