



FLEXIBLE BENEFITS PLAN YEAR _____
REIMBURSEMENT REQUEST FOR
MEDICAL EXPENSES AND
DEPENDENT CARE EXPENSES

State of Tennessee Treasury Department
 502 Deaderick Street
 Nashville, TN 37243-0228
 1-877-681-0155 (phone) or 615-401-6815 (fax)
 www.tn.gov/treasury/flex

Be sure to read the instructions on the back of this form before completing. Please print or type. Requests can be mailed, faxed or scanned and emailed to the Flexible Benefits Office. Keep a copy for your records.

PARTICIPANT INFORMATION

Name _____	Edison ID # _____	Social Security # _____
Email Address _____	Daytime Phone # _____	Department _____

UNREIMBURSED MEDICAL EXPENSES

Service Received* Month/Day/Year	Name of Service Provider *	Amount	Service Received* Month/Day/Year	Name of Service Provider *	Amount
1.			5.		
2.			6.		
3.			7.		
4.			8.		
Total Requested					\$

FOR TREASURY USE ONLY

Service From	Service To	Submitted Amount \$	Denied Amount \$	Total Amount Paid \$
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DEPENDENT DAY CARE EXPENSES

Dependent's Name	Age	Date(s) Service Received* Month/Day/Year	Service Provider ** Type of Service	Provider's Tax ID or SSN	Amount
1.					
2.					
3.					
4.					
Total Requested					\$

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Service From	Service To	Submitted Amount \$	Denied Amount \$	Total Amount Paid \$
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* Use the date the service was received, not the date you paid for it. If service was received on more than one day, show the beginning date and the ending date.
 ** Provider means hospital, doctor, dentist, drugstore, day-care center, special school, etc.

The undersigned participant certifies the following:

- ◆ The expenses have not been reimbursed and are not reimbursable under any other health plan coverage.
- ◆ The undersigned fully understands that he/she alone is fully responsible for the accuracy of all information relating to this claim and that unless an expense for reimbursement is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, and FICA tax on amounts paid from the Plan which relate to such expense.

_____ Signature _____ Date _____

Attach photocopies of receipts from your service provider if the expense was not covered by insurance. If the expense was covered by insurance, submit a copy of your Explanation of Benefits (EOB) from your insurance provider.

INSTRUCTIONS FOR REIMBURSEMENT REQUESTS

General Instructions:

- Please include your eight digit Edison Employer ID number. This is not your Edison User ID nor your Edison password.
- You may not request reimbursement until the service has actually been received, regardless of when you pay for it.
- All expenses claimed must be incurred during your period of coverage. It is not when you pay an expense, but when you incur it that makes it eligible for reimbursement. An expense is "incurred" when you are actually provided with the service that gives you the expense, not when you are formally charged for, billed for, or when you pay for the service.
- If you are making multiple payments for a single service, send your statement showing date of service and total amount due with your first reimbursement request.
- If date of service begins in one plan year and ends in the next plan year, a separate reimbursement form for each year is required.
- Any unused year-end balance in your reimbursement account may not be carried over to the next plan year. It will be forfeited to the state and used to pay administrative costs of the FSA Program.
- You have 90 days after the end of the plan year to submit claims for expenses incurred during your period of coverage.
- Be sure to sign and date the form.
- Expenses reimbursed through a reimbursement account may not be claimed on your income tax return.
- If your state paycheck is deposited directly into your bank account, your reimbursement payments will also be deposited directly to your bank account. If you are not enrolled in the state's direct deposit program, your reimbursement payments will be mailed to you.

Additional Medical Expense Reimbursement Account Instructions

- Attach photocopies of receipts from your service provider if the expense is not covered by insurance. If the expense would normally be covered by insurance, you need only submit a copy of your Explanation of Benefits from your insurance provider.
- Medically necessary orthodontia is considered an ongoing service whose expenses are reimbursable while the appliances are in place. Reimbursement of monthly (or contractual) payments is eligible until the appliances are removed.

Additional Dependent Care Reimbursement Account Instructions

- Dependent care reimbursement requests must be submitted with receipts from the provider with the name, address, and tax ID number (or social security number) of the provider. Requests cannot be processed without this information.
- Dependent care expenses claimed must have been incurred to allow you (if single) or you and your spouse (if married) to work or look for work, or because your spouse is a full-time student or incapable of self care.
- If your dependent care request exceeds your balance, the remaining portion of the reimbursement will be held until your next payroll deduction.

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