SISC Flex Card and Health Care Claim Form

Employee Name:_____ Social Security #: _____

E-mail Address:_____ Phone#_____ District: _____

Indicate type of transaction below. (Optional worksheet is available on our website to help you sort and itemize your expenses.)

☐ **SISC Flex Card** (Verification of expense charged to my SISC Flex account.) **Claim Amount $_____**
Documentation must be received by the SISC Flex office within 40 days after purchase or card privileges will be suspended. Please do not highlight or tape receipts as this may cause the required information to be unreadable. You may circle or put a checkmark by the expense(s) you are claiming.

☐ **Manual Claim** (Request reimbursement for out-of-pocket expense.) **Claim Amount $_____**
Please do not highlight or tape receipts as this may cause the required information to be unreadable. You may circle or put a checkmark by the expense(s) you are claiming.

Employee's Certification: ***I certify that the attached expense(s) were incurred by me (or my spouse or eligible dependent) and were not reimbursed by any other plan, and are not for general health or cosmetic purposes.*** *If the expense is for my spouse or dependent, I certify that the person listed on the attached documentation is my spouse or meets the definition of eligible dependent under the plan. To the best of my knowledge and belief, request for repayment of out-of-pocket expenses are eligible for reimbursement under my SISC Health FSA plan. I (we) will not use the expense claimed through this account as credits or deductions when filing my (our) income tax return. Further, I understand that I have 90 days (run-out period) following the end of the plan year to file claims for the current year. Expenses for all claims must be incurred during the current plan year, or the grace period (2 ½ months following the plan year-end) associated with that plan year. If there is a question regarding eligibility of expenses or the dependency status, SISC may request additional information. All claims and supporting documentation must be received by the SISC office no later than March 31st.*

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:_____ **Date**: _____

Mail Claim Form and Supporting Documentation to:
SISC Flex, P.O. Box 1808, Bakersfield CA 93303-1808 ♦ Or FAX to (661) 636-4063
E-mail Address: siscflex@kern.org
SISC Flex website: http://sisc.kern.org/flex/

Eligible reimbursements will be paid by check and mailed to your home address, or directly deposited to your bank account when authorized.
Please notify your employer of a change in address as soon as possible.
Please retain a copy of the claim form and supporting documentation for your records.

SUPPORTING DOCUMENTATION MUST ACCOMPANY ALL CLAIM FORMS

► For **prescription drugs**, attach a legible receipt from the service provider, which includes the: 1) Date prescription was purchased; 2) Drug name and prescription number, or the Rx label; 3) Amount of purchase; 4) Name of the pharmacy; and 5) Patient name. The Rx ticket typically contains all required information.

► For **medical, dental, vision and other health care expenses,** documentation must include a legible copy of the provider's itemized statement of the charges including: 1) Provider's name and address; 2) Date of service or purchase; 3) Description of service or product; 4) Amount charged for service or product; and 5) Patient name. A copy of the Explanation of Benefits (EOB) is acceptable and preferred.

► For eligible **over-the-counter (OTC) expenses**, the item must be clearly defined on the receipt indicating: 1) Date of purchase; 2) Amount of purchase; 3) Name of the product; and 4) Merchant name and address. If the item is abbreviated on your receipt, you must attach a photocopy of the package label showing the full product description. OTC drugs and medicines must be prescribed.

Incomplete claim form or supporting documentation may delay processing or result in a denied claim.

For SISC Use Only

Authorization _____ Date_____ SF Approved _____ SF Pending _____ SF Denied _____

Reimbursement Approved _____ Reimbursement Denied _____ Claim # _____

Explanation: _____

Rev. Jan 2012