PLEASE DO NOT STAPLE

FSA Claim Form

Health Care FSA
Dependent Care FSA

TRI-STAR SYSTEMS
16401 Swingley Ridge Road, Ste. 250
Chesterfield, MO 63017
Phone: 800-727-0182 Fax: 800-818-0829
www.tri-starsystems.com

Stop! Go to www.tri-starsystems.com to:
** Skip this form & Efile (processing priority)*
** Set up direct deposit (faster payment)*
** Check your address (for check mailing)*

PART 1 - COMPLETE FOR ALL CLAIMS

Caution: Checks may be delayed for invalid addresses. Sign up for Direct Deposit!

SSN/Acct | Last Name | First Name | Initial

Address

City | State | Zip Code | Phone #

Employer Name | Email

PART 2 - DEPENDENT CARE (DCSA)

Helpful Hint: Use "Provider Certification" below if receipts are not attached/provided

Dependent Name	Age	Service Start Date mm/dd yy	Service End Date mm/dd/yy	Provider Name	Provider Tax ID/ SSN	Amount Claimed

Total DCSA Claimed: $0.00

DEPENDENT CARE Provider Certification (optional, instead of providing receipts) - Complete PART 2 above, then have provider sign

I certify the information listed in Part 2 above is correct, signed (below):

Provider Name (print)	Authorized Provider Signature	Date Signed

PART 3 - HEALTH CARE (HCSA)

Helpful Hint: See below for explanation of a "Valid Receipt"

Patient Name	Service Date mm/dd/yy	Description of Service	Provider Name	Amount Claimed	Used Debit Card Y or N

VALID RECEIPT: For each item claimed, provide: a provider statement showing the dates & description of services, patient name & fee. If the services provided are covered by insurance, provide the insurance company Explanation of Benefits (EOB) & then provide the EOB to us instead of the provider statement. All non-supported items cannot be processed.

Total HCSA Claimed: $0.00

PART 4 - Acknowledgement and Signature - I certify that 1) all services and expenses for which reimbursement is claimed by submission of this form were received by me or an eligible dependent, 2) all medical expenses claimed have not been reimbursed and will not be presented for reimbursement through any other health plan, 3) I am responsible for any inappropriate use or disclosure of my information that occurs due to the method I have selected for transmitting this information, 4) I alone am fully responsible for the accuracy of all information I have provided by submission of this claim form, and 5) by providing incomplete, false, or misleading information on this form that I may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan made in error.

Employee Signature	Date