

## **How to Submit**

Secure Upload: Via Employee Portal

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# FSA/DCA Card Claim Form

Participant Information	To Update your information, log on to your account at www.basiconline.com/account_access				
Employer:					
Name:	Social Security #:				

## **Eligible Medical & Dependent Care Expenses**

### **Medical Expenses:**

- Documentation for each request must show
  - Date(s) of service
  - Description of service provided
  - o Charge for the service
  - Provider's name and address.

#### **Over-the-Counter Items:**

 Any items considered to be a "medicine", i.e. Tylenol®, cold medicine, Ibuprofen etc., will require a Letter of Medical Necessity (LMN) from your medical provider. LMN is good for one year from date of issue.

### **Dual Purpose Procedures:**

Some medical treatments such as massage therapy and gym memberships will also require a Letter of Medical Necessity.

## Dependent Care (Day Care) Expenses:

- Documentation for each request must show
  - Date(s) of service
  - Name of provider/day care center
  - Charge(s)/Amount for careProvider's name and address

## Eligible Expenses:

- Child(ren) must be under the age of 13
- Care for child(ren) while you and your spouse are working
- Care for a dependent that is physically or mental not able to care for oneself.

### **Expenses Not Eligible:**

- Care for Child(ren) over the age of 13
- Overnight camps
- Care for child(ren) while you are not working (vacation, leave of absence, day off, etc)

Signature of Day Care Provider:				
Your provider may sign this form on the line above or provide a receipt for services.				
Itemized Medical & Dependent Care Expenses	_			

Benefit Card used for this expense [please check yes or no]  Medical or Day ( [please check e			Date(s) of Service [provide the date or date range which service(s) were provided]	Service Provider [The name of the provider who provided the service]	Amount [Enter the reimbursement amount requested]	
Yes	No	Medical	Day Care			\$
Yes	No	Medical	Day Care			\$
Yes	No	Medical	Day Care			\$
Yes	No	Medical	Day Care			\$
Yes	No	Medical	Day Care			\$

I certify that I have not already been paid for these expenses from my Medical/Dependent Care Plan or any other source. I have submitted the above
information in good faith and it is correct to the best of my knowledge. I understand that reimbursement is not a guarantee. The service for which I am
requesting reimbursement must be incurred during my period of participation. Services incurred after participation ends are not eligible for reimbursement
even if there was a balance remaining in my account.

Signature:	Date	
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