MAYO CLINIC

Health Care Flexible Spending Account

Claim Form

Please complete, print and submit.

Reset Form

1. Before submitting a claim for reimbursement from your Health Care Flexible Spending Account, you must first file for benefits covered under any other medical, dental, HMO plans or reimbursement accounts.*
2. Complete Sections I, II and III.
   - If you have received coverage for the item under a health plan (including Mayo Medical Plan), please submit your Explanation of Benefits (EOB) with your claim form.
   - Attach an itemized statement and/or receipt for each item you would like reimbursed (an EOB may be used in place of an itemized statement).
3. Submit completed original claim form with EOB or itemized statement/receipt to the address shown at right.
4. Dates of service must be incurred within the same calendar year as pretax contributions.
5. **Claims will not be processed without a signed claim form.**

Mail To: Health Care Flexible Spending Account Claims
Mayo Clinic Health Solutions
PO Box 211698
Eagan, MN 55121

Intra-clinic Mailing
Address: Health Care Flexible Spending Account Claims
Mayo Support Center North
SN 3

Phone: 6-6360 (on Mayo Clinic campus)
(77)6-6360 (on other Mayo Clinic campus)
507-266-5580 (local)
1-800-635-6671 (toll-free),1-800-407-2442 (TDD)

Fax: 1-855-619-0010 or 1-507-284-9297

Email: HealthSolutionsClaims@mayo.edu

SECTION I

Employee Name *(First, Middle, Last)*		Mayo Employee ID Number *(See Quarterly directory on Mayo Intranet)*	
Work Phone	Home Phone	Social Security No. *(Last 4 Digits)*	Birth Date *(Month DD, YYYY)*
Address *(Street)*		City	State / ZIP Code

Category: ☐ Voting/Consulting Staff ☐ Fellows or other Mayo Appointees ☐ Allied Health Staff ☐ COBRA

SECTION II

Service Date *(Month DD, YYYY)*	Eligible Expenses Description	Individual Receiving Care Name/Relationship	Total Amount of Bills	Amount Paid By Any Other Plans	Amount to be Reimbursed
Example 01/10/2011	Prescription copayment	Jane Anderson/Daughter	$10	$0	$10
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
				Total:	$0.00

SECTION III – Account Holder Certification

I authorize the expenses above to be reimbursed through my Health Care Flexible Spending Account. I certify that, to the best of my knowledge, the expenses I am submitting meet the requirements of qualified health care expenses as covered by this plan as explained on the back of this form and that my dependents are persons who qualify under the Internal Revenue code section 152. I further certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse, or another member of my family.

Account Holder Signature Signature Required **Date** *(Month DD, YYYY)*

(Signature required)

Processing Guideline: All completed claim forms received by 5:00 p.m. on any given payday will be processed by the following payday. Your reimbursement will be included in your statement of earnings listed as: HealthCareReimbursement

* The Mayo Reimbursement Account or Dental Assistance Plan must be exhausted before you use your pretax Health Care Flexible Spending Account for eligible dental and vision expenses.

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GENERAL INFORMATION

Eligible health care expenses for which you submit a claim must be incurred while you are a participant, in the plan calendar year, and must not be reimbursed by any insurance, other reimbursement accounts, or an HMO. You may not claim a medical expense deduction on your income tax return for which you were reimbursed from your Health Care Flexible Spending Account. The maximum annual contribution is $2,500 per employee. If both you and your spouse are benefit-eligible employees at Mayo Clinic, each of you may contribute up to $2,500. You may be reimbursed for health care expenses incurred by you on behalf of yourself, your spouse, or your dependents. Your "dependents" are persons who qualify as dependents on your federal tax return. The term "dependent" does not include any individual who is not a US citizen or national, unless the individual is a resident of the US or a country contiguous to the United States.

Fraud Warning

- **A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.**

Examples of **eligible** health care expenses are:

- Acupuncture treatment
- Braille books
- Christian Science Practitioner charges
- Chiropractic charges
- Contact lenses* (includes materials and equipment needed to maintain lenses: cleaner, saline, etc.)
- Convalescent home medical treatment
- Dental treatment and deductibles*
- Eye examinations, prescription eyeglasses*
- Hearing aids and batteries
- Hospital and physician charges
- Kidney donor's expenses
- Laser eye surgery for vision correction (LASIK)
- Medical care plan deductibles and co-pays
- Nursing charges for medical services
- Over-the-counter pharmaceuticals that are accompanied by a prescription from a licensed physician OR over-the-counter insulin
- Orthodontia (see special requirements on claim filing)
- Prescription drugs and deductibles
- Special costs for physically and mentally handicapped children

Examples of **ineligible** health care expenses are:

- Cosmetic surgery
- Clip-on or non-prescription sunglasses
- Custodial care
- Dental services for bleaching of teeth
- Dietary supplements, toiletries and cosmetics
- Drugs for cosmetic purposes (Retin-A, Rogaine, Propecia, etc.)
- Electrolysis
- Fitness programs and/or health club dues
- Hair transplant
- Over-the-counter pharmaceuticals not accompanied by a prescription from a licensed physician, with the exception of over-the-counter insulin
- Vitamins and herbal supplements

Special Requirements for Claim Filing for Orthodontia:

If you are using this account for orthodontia, an itemized statement and/or copy of your contract outlining the treatment plan must accompany your claim for each year you participate. If you choose, you may file the entire amount of your orthodontic claim, regardless of the length of treatment. You may also file claims as you incur the expense, however, remember an itemized statement must accompany each request. The maximum annual contribution is $2,500 per employee. If both you and your spouse are benefit-eligible employees at Mayo Clinic, each of you may contribute up to $2,500. When using your Health Care FSA to reimburse for orthodontia treatment, you may file the entire amount of your orthodontic claim, regardless of the length of treatment.

Claim Filing Deadline:

March 31 of the following year is the deadline to submit claims for expenses incurred in the calendar year in which pretax contributions were made. Any funds remaining in your Health-Care Flexible Spending Account after the deadline are forfeited.

***** Eligible expenses must first be filed for benefits under any other medical, dental, HMO plans or reimbursement accounts. The Mayo Reimbursement Account or Dental Assistance Plan must be exhausted before you use your pretax Health Care Flexible Spending Account for eligible dental and vision expenses. Dental Assistance Plan members can use their Health Care Flexible Spending Account for vision services before their Dental Assistance Plan is exhausted; due to the fact that the Dental Assistance plan does not reimburse for vision.

For a complete description of the Health Care Flexible Spending Account, refer to the Summary Plan Description. Go to the Mayo Intranet, then go to "For You," "Human Resources" and click on "Benefits."

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