How To Submit A **Reimbursement Claim (FSA)**

All sections of the claim form must be completed in order to receive reimbursement.

Claim Form Section 1: Employee Information

The following information must be included for each claim:

- Employee (Participant) Social Security Number
- Employee Name
- Employee Address
- Employee Phone Number

Claim Form Section 2: Claim Information

The following must be included for each claim:

For Medical Expenses

- Date of Service
- Patient Name
- Name of Provider
- Description of Service
- Amount of Claim

For Dependent Care Expenses:

- Date of Service
- Dependent Name
- Dependent Age
- Name of Care Provider
- Care Provider Address
- Provider Tax ID/SSN
- Amount of Claim

For Medical Expenses, you must provide a provider receipt or insurance carrier explanation of benefits (EOB) that contains ALL of the information listed under "For Medical Expenses" above. Cancelled checks, non-detailed credit card receipts, or generic cash receipts do not provide all the information necessary to substantiate claims and cannot be accepted. Statements with "Previous Balance", "Balance Forward", or "Paid on Account" do not contain all of the necessary information and cannot be accepted.

For Dependent Day Care Expenses, you must provide either a receipt that contains ALL of the information listed under "For Dependent Day Care Expenses" or a signature of the Care Provider on the completed claim form. Expenses submitted for Dependent Care reimbursement must allow the participant to be gainfully employed (or looking for work). Overnight camps, extracurricular activity fees, care for children over the age of 12, and private school fees (for grades Kindergarten and up) are not eligible expenses for Dependent Care reimbursement.

Claim Form Section 3: Signature

The participant must sign and date the claim form in order for the claims to be reimbursed.

For Reimbursement

- Upload with the myRSC Mobile App using SnapClaim™; or,
- Enter the claim online and upload receipts via the myRSC participant portal
- Fax claim form and receipts to Little Rock **(501) 687-3282 / Toll Free 1-888-472-6777**; or,
- Email claim form and receipts to **benefits@datapathadmin.com**; or,
- Mail claim form and receipt copies to: **DataPath Administrative Services, 1601 Westpark Drive, Suite 9, Little Rock, AR 72204**

For a list of eligible expenses, see pages 5 or visit datapathadmin.com

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP

DataPath Administrative Services, Inc. | 1601 Westpark Drive, Ste 9 Little Rock, AR 72204 | Toll-Free 877-685-0655
Phone 501-687-6954 | Fax 501-687-3282 | Toll-Free Fax 888-472-6777 | benefits@datapathadmin.com | www.datapathadmin.com

Claim Form – Health FSA Reimbursement or Card Substantiation

☐ *Please check here if new mailing address* ☐ *Please check here if new email address*

Section 1: Employee Information

Employer Name (Please Print) _____

Employee Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Employee Email Address _____

Section 2: Claim Information

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.
All information below must be completed.

Debit Card Purchase?	Service Date (mm/dd/yyyy)	Patient Name & Relationship	Provider Name & Address	Description of Service	Amount
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
				Total	$

Section 3: Signature

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee's Signature _____ Date ____/____/____
mm/dd/yy

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP

DataPath Administrative Services, Inc. | 1601 Westpark Drive, Ste 9 Little Rock, AR 72204 | Toll-Free 877-685-0655
Phone 501-687-6954 | Fax 501-687-3282 | Toll-Free Fax 888-472-6777 | benefits@datapathadmin.com | www.datapathadmin.com

Claim Form – DCAP Reimbursement

☐ *Please check here if new mailing address* ☐ *Please check here if new email address*

Employer Name (Please Print) _____

Employee Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Employee Email Address _____

Dependent Care Claims

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim. Use a copy of this form if you need more space. All information below must be completed.

Service Period						
From	To	Dependent Name	Age	Provider Name & Address	Provider Tax ID#/SS#	Amount
						$
						$
						$
						$
						$
					Total	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee's Signature _____ Date / /
mm/dd/yy

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP

DataPath Administrative Services, Inc. | 1601 Westpark Drive, Ste 9 Little Rock, AR 72204 | Toll-Free 877-685-0655
Phone 501-687-6954 | Fax 501-687-3282 | Toll-Free Fax 888-472-6777 | benefits@datapathadmin.com | www.datapathadmin.com