

City of Newton  
Flexible Spending Account (FSA)  
**CLAIM REIMBURSEMENT REQUEST**

Address Change

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (     ) \_\_\_\_\_

E-MAIL ADDRESS: *(Optional)* \_\_\_\_\_

**OUT-OF-POCKET MEDICAL EXPENSE** not covered by other medical benefit plans.  
(For Participants & Eligible Dependents -*as defined by the IRS guidelines*)

ITEMS (group similar items)	DATES INCURRED (start/end dates)	AMOUNT
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
		TOTAL: \$ _____

**DEPENDENT/CHILD CARE EXPENSES** (Daycare)

_____	_____	\$ _____
_____	_____	\$ _____

All medical claims submitted require copies of bills/statements/receipts showing date and type of service. (No cancelled checks/credit card receipts). All claims must be received two days prior to claim payment day. Direct deposit payments are processed weekly on Wednesday, usually available in your bank on Thursday. Checks are issued twice a month (every other Wednesday). Please allow 3 business days to receive your check. Minimum payment for Medical Expenses is \$20.00.

**This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's FSA. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses has previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. Additionally, I am aware that unused funds may be forfeited or otherwise handled in accordance with the plan document and the current IRS law. I hereby request reimbursement for these claims.**

PARTICIPANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CITY OF NEWTON  
CLAIM PROCESSING & PROCEDURES

- **PAYMENTS:** Checks are issues twice a month (every other Wednesday).

Direct Deposit payments are processed weekly (Wednesday). Please allow up to two business days for funds to be in your account. All claims must be received by Monday to be included.

- All medical claims submitted require copies of bills/statements/receipts showing date and type of service. (No cancelled checks/credit card receipts).
- All claims must be received **two days prior** to the claim payment day.
- You may fax a claim and your receipts to CPA, Inc. Please limit fax to 10 pages.
- All expenses must be incurred (service date) during the Plan Year, not when you were billed or paid the expense.
- You may group expenses together on one line (see example below).

<u>ITEMS</u>	<u>DATE INCURRED</u>	<u>AMOUNT</u>
Co-pays (Medical)	1/6/09 - 5/31/09	200.00
Co-pays (Prescriptions)	2/1/09 - 3/31/09	150.00
Dental Expenses	2/28/09 - 3/15/09	750.00

IRS Reimbursable Expenses (examples). Please call CPA, Inc. if any questions.

Acupuncture	Insulin and Testing Supplies
Alcohol/Drug Therapy	Medications
Birth Control Pills	Mileage – (.24 -2009, call for current rate)
Braces (Orthodontics)	Nursing Services
Chiropractors	Orthopedic Shoes
Co-payments for Doctor, Dental	Osteopath
Contact Lenses and Solution	Over-the-counter <u>Medicines</u>
Dental Fees – <u>No bleaching</u>	Prescriptions/Co-Pays
Dentures	Psychologist Fees
Eye Exams and Glasses	Psychiatric Care
Eye Surgery (Laser)	Physical Therapy
Handicapped/Hearing Impaired/Sight	Surgical Fees
Impaired/Learning Disabled	Therapy (Physical and Occupational)
Hearing Aids and Batteries	Viagra
Hospital Care/Services	



The following items require a physician prescription each plan year stating the expense is necessary to treat a particular medical condition/disease. Wellness procedures and programs are NOT covered.

Health Club memberships	Weight Loss Programs
Muscular Therapy	Vitamins

Cafeteria Plan Advisors, Inc.  
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