

Limited Flexible Spending Account (LFSA) Claim Form



Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Minimum Total Reimbursement = \$25
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

****Notice****

Claims submitted on this form are for Limited FSA expenses and may include the following: Dental, Vision, Preventative Care. Please refer to your current SPD to determine which expenses apply.

1 Personal Information

Employee Name _____

Company Name _____

Street Address, City, State, Zip _____

No Yes
Address Change?

Phone Number _____

Social Security Number _____

2 Dependent Care Expenses

	Date of Service			Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
	MM	DD	YY				
1	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____
Total Dependent Care Expenses							_____

3 Limited Health Care Expenses

	Date of Service			Dental	Vision	Person Receiving Service	Amount
	MM	DD	YY				
1	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
2	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
3	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
4	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
5	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
7	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Total Health Care Expenses							_____

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____

Date _____

Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084
Fax: (844) 438-1496
Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)