



FlexSystem™ REQUEST FOR REIMBURSEMENT

Client Name **TASC**
Participant TASC Id

PLEASE DUPLICATE THIS FORM FOR FUTURE REQUESTS

Submit Request for Reimbursement:
For claims submitted online: only print and fax the Veriflex Coversheet from the web along with your receipts to the fax number located on the cover sheet.

Claims submitted with RFR Form should be sent to TASC:

a. By Fax: 608-663-2762
b. Or by Mail: TASC
PO BOX 7308
Madison, WI 53707-7308

New Address, check here and update - please print
If updates were sent previously, please use your new updated RFR form

WRITE LEGIBLY AND DO NOT HIGHLIGHT AMOUNTS ON YOUR RECEIPT
ALL BOXES AND FIELDS MUST BE COMPLETED
SUBMIT A COPY OF YOUR RECEIPT ALONG WITH THIS RFR
ONLY FOUR LINES PER FORM WILL BE PROCESSED

Receipt Attached	Date of Service (not billing or paid date)	Benefit Code*	Service Type Code**	Request Amount	Service Provider(s)
<input type="checkbox"/>	___/___/___	___	___	_____.____	
<input type="checkbox"/>	___/___/___	___	___	_____.____	
<input type="checkbox"/>	___/___/___	___	___	_____.____	
<input type="checkbox"/>	___/___/___	___	___	_____.____	

BENEFIT CODES

M - Medical (Out-of-Pocket) Expenses

SERVICE CODES

MD - Medical

VS - Vision

RX - Prescription Drugs

DN - Dental

OT - Over-the-Counter

MP - Medical Preventative

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my FlexSystem account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. I authorize my Flexible Spending Account balance to be reduced by the amount requested.

Employee Signature (required)

Date / /



REIMBURSEMENT TIPS

When paying for an eligible expense, simply swipe your TASC Card at the point-of-purchase. The TASC Card automatically pays for and substantiates expenses, eliminating the need to submit reimbursement requests. If you are unable to pay for an expense with your TASC Card, simply submit a reimbursement request online via the MyTASC Mobile App (free download from Amazon, Apple App Store, and Android Google Play) or Request for Reimbursement Wizard in MyTASC (www.tasconline.com). Online requests are faster, greener, better!

If you do not have online or mobile access, complete and submit your personalized Request for Reimbursement Form via fax or mail. (Please allow extra time for the processing of paper forms.)

Follow these helpful tips for prompt and accurate reimbursements:

- Use only your personalized Request for Reimbursement Form. Download additional forms from your MyTASC account (www.tasconline.com) and/or duplicate this form for future requests. Non-conforming or incomplete forms will be rejected. One request form can be used for multiple expenses.
- When completing the Request for Reimbursement Form, enter each different expense on a separate line, identifying the date of service, the benefit type, the service type, and the service provider. Date of service always represents the date your services are incurred or rendered.
- Enter the appropriate benefit and service codes. See front side for a list of codes. Enter the amount requested for each Benefit Code in the Request Amount field for that benefit.
- Copy your original receipts to an 8 1/2 x 11 sheet of paper. (Retain originals for your records.) Do not submit receipts alone. Always place the applicable form on top of your receipts. Do not highlight information on the form or receipts. When faxing, ensure forms are not faxed upside down or backwards.
- If submitting multiple Requests for Reimbursement Forms, receipts must be placed directly behind the applicable Reimbursement Form. If one receipt covers expenses on multiple Reimbursement Forms, submit a copy of the receipt behind each applicable Reimbursement Form.
- Remember to sign and date all forms submitted to FlexSystem.
- Send copies of the receipts with your Request for Reimbursement Form to FlexSystem via the fax number or address listed on the front of the form. Receipts for already-submitted requests may also be uploaded online: login to MyTASC, click Account Management, then click the Reimbursements tab. Under Submitted RFRs, click Upload Receipt.
- All Participants are expected to submit supporting records and documents to validate the expense type and amount. These expenses are verified by FlexSystem and in some instances, additional information or documentation may be required prior to processing a claim.
- FlexSystem processes reimbursements daily. Reimbursement payments are initiated within 48 to 72 hours of receipt of a complete and accurate reimbursement request.
- Access account status information online at www.tasconline.com or call TASC. You will need your TASC ID to access this information from the Interactive Voice Response System and to initially access this information via the website.
- Please note, if your employer has elected Claim ConneX and you are enrolled in Claim ConneX for your Medical Out-of-Pocket FlexSystem Plan, your medical insurance provider automatically submits the unpaid portions of your medical claims to TASC for processing. Those claims will be automatically reimbursed to you from your Medical Out-of-Pocket FlexSystem Plan. No action is required from you to receive reimbursement for those claims. In addition, if your employer's FlexSystem Plan has Reimbursement Ordering and you have a Medical Out-of-Pocket FlexSystem Plan and a DirectPay Plan, requests submitted via the online Request for Reimbursement Wizard or via your medical insurance provider (Claim ConneX) will automatically be routed to your Plan that reimburses first and then to the Plan that reimburses second for processing.

REQUEST FOR REIMBURSEMENT

For each request entered, all boxes must be completed. Please check the appropriate box to indicate all attached receipts or substantiating documents.

Req. Attach	Date of Service (or Billing or paid date)				Benefit Code	Service Type Code	Request Amount	Service Provider(s)					
	Month	Day	Year										
<input type="radio"/>	1	2	0	5	0	3	M	R X	83	1	8	Walgreens	
<input type="radio"/>	1	2	1	0	0	3	M	C P	6	0	0	Dr. Jones	
<input type="radio"/>	1	2	1	1	0	3	M	D P	1	1	6	9	Dr. Carter
<input type="radio"/>	1	2	1	8	0	3	D	D C	2	0	8	3	Kid Keepers Center

BENEFIT CODES:
M = MEDICAL EXPENSE - OUT-OF-POCKET
D = DEPENDENT CARE/DAY CARE