



How to Submit
 Secure Upload: Via Employee Portal
 Fax: 269-327-0716
 Mail: BASIC•9246 Portage Industrial Dr. •Portage, MI 49024

**FSA/DCA Card
Claim Form**

Participant Information To Update your information, log on to your account at www.basiconline.com/account_access

Employer: _____

Name: _____ Social Security #: _____

Eligible Medical & Dependent Care Expenses

Medical Expenses:

- Documentation for each request must show
 - Date(s) of service
 - Description of service provided
 - Charge for the service
 - Provider's name and address.

Over-the-Counter Items:

- Any items considered to be a "medicine", i.e. Tylenol®, cold medicine, Ibuprofen etc., will require a Letter of Medical Necessity (LMN) from your medical provider. LMN is good for one year from date of issue.

Dual Purpose Procedures:
 Some medical treatments such as massage therapy and gym memberships will also require a Letter of Medical Necessity.

Dependent Care (Day Care) Expenses:

- Documentation for each request must show
 - Date(s) of service
 - Name of provider/day care center
 - Charge(s)/Amount for care
 - Provider's name and address

Eligible Expenses:

- Child(ren) must be under the age of 13
- Care for child(ren) while you and your spouse are working
- Care for a dependent that is physically or mental not able to care for oneself.

Expenses Not Eligible:

- Care for Child(ren) over the age of 13
- Overnight camps
- Care for child(ren) while you are not working (vacation, leave of absence, day off, etc)

Signature of Day Care Provider: _____
 Your provider may sign this form on the line above or provide a receipt for services.

Itemized Medical & Dependent Care Expenses

Benefit Card used for this expense [please check yes or no]	Medical or Day Care Expense [please check expense type]	Date(s) of Service [provide the date or date range which service(s) were provided]	Service Provider [The name of the provider who provided the service]	Amount [Enter the reimbursement amount requested]
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Day Care			\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Day Care			\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Day Care			\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Day Care			\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Day Care			\$

I certify that I have not already been paid for these expenses from my Medical/Dependent Care Plan or any other source. I have submitted the above information in good faith and it is correct to the best of my knowledge. I understand that reimbursement is not a guarantee. The service for which I am requesting reimbursement must be incurred during my period of participation. Services incurred after participation ends are not eligible for reimbursement even if there was a balance remaining in my account.

Signature: _____ Date: _____