CrawfordAdvisors, LLC
HEALTH CARE FSA REIMBURSEMENT FORM

SUBMIT CLAIMS BY:
FAX: 410-771-9487

MAIL: Crawford Advisors, LLC
c/o FSA Claims Processing
200 International Circle, Suite 4500
Hunt Valley, MD 21031

FOR PARTICIPANT QUESTIONS, CONTACT US…
- Customer Service Center 1-800-657-6265
- E-mail: fsa@crawfordadvisors.com

Health Care Reimbursement Account Claims *(for you and your tax-qualified dependents)*

Please complete this form and attach your Insurance Explanation of Benefits (EOB) or itemized statement from the provider. The itemized statement **must** show the **provider name and address, patient name, date and description of service(s), and itemized charges**. Orthodontia claims require an itemized statement and the orthodontist's contract or payment agreement, showing the monthly payment. You must attach the itemized receipts. For qualified over-the-counter purchases, you must submit evidence of the purchase date and the specific medicine and/or drug name. Please provide copies only. Keep all originals, including original receipts. Do not send original receipts. It is highly encouraged that over-the-counter (OTC) claims be submitted by fax (note, as of 1/1/2011, OTC purchases may require a doctor's prescription).

Health Care Reimbursement Claims Submission
(claims may be submitted by the following methods)

FAX Preferred Method (especially for over-the-counter claims): Fax this completed form with a copy of all supporting documentation to 410-771-9487.

MAIL This claim form may be submitted by MAIL with a copy of all supporting documentation to Crawford Advisors, LLC at the address above.

Please complete the information below:

* Employee Name	* Employer's Name	* Division (if applicable)	
* SSN/ID#	* Daytime Phone	Email Address (optional)	
* Address	* City	* State	* Zip

NOTE: You must list each receipt individually on the claim form. There is one line for each receipt. Do not aggregate receipts by combining two or more receipts into one line on the claim form. Attach additional claim forms as necessary to submit more claims.

*Dates of Service (MM/DD/YY) Start	End	*Patient Name	*Relationship to Participant	*Name of Provider/Pharmacy	*Description of Service/Medicine/Drug	*Reimbursement Requested
					***Total Reimbursement**	

***REQUIRED INFORMATION**

I certify that the medical care expenses submitted for reimbursement were rendered to me or an eligible member of my family during the period I was a participant in the Health Care Flexible Spending Account. I further certify that the medical care expenses are not eligible to be paid by the health care coverage provided through my employer or from any other source, such as my spouse's employer's health plan. I understand that I have the responsibility for any tax reporting or other requirements with respect to reimbursed expenses. I also understand that to the extent medical care expenses are reimbursed under the Health Care Flexible Spending Account, I will not claim them as expenses for purposes of the tax deduction against income tax for medical care. I also understand that the charges for which I am submitting reimbursement are eligible charges in accordance with IRS guidelines and IRS Publication 502. I certify that **all over-the-counter medicine or drug expenses were incurred for medical care**. I agree that I am responsible for any and all bank, savings, or checking account charges that I incur. I agree to indemnify and hold harmless Crawford Advisors, LLC from any responsibility relative to my credit status. I have received and read all printed material describing this program and all administrative materials defining the operation of this plan. I certify that I am responsible for compliance with all applicable administrative processes, tax regulations and documentation. I will retain a copy of this form and all original receipts for my records.

12.04

(Participant Signature) (Date)