Request for Reimbursement
FSA Claim Form

Employer Name_____

Employee Last Name _____ First Name_____ Middle Initial _____

Social Security Number _____ Email _____ Phone (____) _____

Address_____City_____State_____Zip _____

☐ **Check here if submitting a Change of Address**

Be sure to provide all information requested in each row as outlined in the 1st row, which is an example. If the form is incomplete, it will be returned to you. You can send this form along with the third-party documentation substantiating your claim(s) to OCA, 3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619, or by email at claims@oca125.com, or fax directly to 609-514-0111, 609-514-0111 (Alternate), 609-570-8980 (Alternate).

Date of Service	Is this for a Card Transaction?	Patient Name	Relation to Employee	Name of Provider	Description of Service	Amount
3/15/19	☐ Yes ☐ NO	John Smith	Spouse	Dr. Jones	Deductible	$ 175.00
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
	☐ Yes ☐ NO					$
					Total:	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:_____ Date:_____/_____/_____
mm/dd/yy