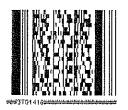
Request for Reimbursement FSA Claim Form





Employer	Name	lownshi	p of Ocean Bo	ard of Educa	ation		
Employee Last Name				First Name		Middle Initial	
Social Security Number				Email		Phone ()	
Address				City		StateZip	
☐ Check here if submitting a Change of Address							
incompleted	e, it will be r o OCA, 3705	eturned to Quakerbrio	you. You can send th	nis form along with Mercerville, NJ 08	n the third-party doc 619, or by email at c	an example. If the form sumentation substantial claims@oca125.com, or	ing your
Date of Service	1	or a Card action?	Patient Name	Relation to Employee	Name of Provider	Description of Service	Amount
3/15/19	Yes	Пио	John Smith	Spouse	Dr. Jones	Deductible	\$ 175.00
	Yes	□ NO					\$
	Yes	Пио					\$
	Yes	Пио					\$
	Yes	Пио					\$
	Yes	Пио					\$
	Yes	Пио	e probabilitaria de mande de m				\$
	Yes	□ NO					\$
	Yes	□ NO				,	\$
	Yes	□ NO					\$
	Yes	Пио					\$
	Yes	□ NO					\$
	Yes	□ №				*	\$
L	1	<u></u>		.	<u></u>	Total:	\$
I certify that reimbursed b use the expe	oy any other pla nse reimbursec 	or reimbursen an, and to the I through this wingly and with	nent requested from my a best of my knowledge and account as deductions or n intent to injure, defraud	d belief, are eligible for credits when filing my , or deceive any insura	reimbursement under m (our) individual income to ance company, administra	ise and/or eligible dependen by Reimbursement Plans. I (or ax return. ator, or plan service provider Il act punishable under law.	we) will not
Employee Signature:						Date:/	/

Request for reimbursement



Employee Signature:





Township of Ocean Board of Education Employee Last Name (Please Print) ______ First Name ______ Middle Initial ______ Address City State Zip Social Security Number______Home Phone (___) _____Work Phone (___) ____ Employee E-mail Address (if any)_____ 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, 609-514-2778 (Alternate), 609-570-8980 (Alternate). Dependent Care Claims Service Period Dependent Name Age Provider Name Service Description Provider Tax ID#/SS# Amount (DCAP) From 02/01/16 02/28/16 123456789 John Smith ABC Day Care **DCAP** \$100 \$ Ś \$ \$ \$ \$ \$ \$ \$ \$ \$ Total Provider's Certification (If the provider signature certification is provided, employees are not required to submit supporting documentation): I certify that I am the above mentioned provider or an authorized representative of the above mentioned provider. I further certify that the services specifically described above were provided by the provider for the above named dependent during the service period specifically described above. NOTE: Do not complete this section if you are not the above mentioned provider or the services described above were not provided (or the participant has not completed the section above). Provider Name______Provider Signature: _____ Date: Providers Tax ID: **Employee's Certification:** I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependent(s), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. 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.