CAPROCK HEALTH GROUP
A Healthcare Services Organization

FORMERLY MAXOR® ADMINISTRATIVE SERVICES

Flexible Spending Account Claim/Reimbursement Form

You may mail, email or fax your completed form too:
Caprock HealthPlans
PO Box 15050
Amarillo, TX 79105
Phone: 806-322-5920 Fax: 806-324-5590
Email: capfsa@caprockhp.com

1. Participant Information and Signature

By submitting this claim form, I (participant named below) request reimbursement from my Flexible Spending Account(s) as listed below. I agree to the Terms and Conditions stated below; I certify and warrant to MAS that these are eligible Unreimbursed Medical and/or Dependent Care expenses (see back) that my dependents or I have incurred.

Participant Name (please print): _____ Social Security Number: _____

Participant Address (complete only if address has changed): _____
Street City State ZIP

Employer Name: _____

How may we contact you during the day? E-Mail: _____ Phone: _____

Participant Signature: _____ Date: _____

2. Dependent Care

List each receipt separately. Use additional forms if necessary. Use the provider certification space below only if no receipt is attached.

Dependent Name	Age	Provider Name	Date Service Provided	Requested Amount

Provider Certification/Verification: I certify that the Dependent Care expenses listed above were incurred by the participant named above.

Provider Address: Street:_____ City:_____ State:_____ ZIP:_____

Provider Signature:_____ Date:_____

3. Unreimbursed Medical

List each receipt separately. Use additional forms if necessary. Use the provider certification space below only if no receipt is attached.

Patient Name	Provider Name	Description of Service	Date Service Provided	Requested Amount

Provider Certification/Verification: I certify that the Unreimbursed Medical expenses listed above were incurred by the participant named above.

Provider Address: Street:_____ City:_____ State:____ ZIP:____
Provider Signature:_____

General IRS Eligibility Guidelines

To qualify for reimbursement from Flexible Spending Accounts, expenses must be incurred during the Plan Year for which you are requesting reimbursement.

1. Unreimbursed Medical Account: Used for medical expenses for you and your family that are not covered by any other health plan.

   Items covered must be for medical care as defined in Section 213(d) of the IRS Code and allowed by the Plan and may include but are not limited to:
   - Major medical copayments and deductibles (excluding insurance premiums of any kind).
   - Certain medical, dental, hearing, and vision services (excluding cosmetic procedures).
   - Most prescribed drugs, contraceptives, insulin, and smoking cessation programs (herbal drugs and over-the-counter drugs may be eligible, if permitted by the Plan and used to treat a medical condition).
   - The purchase and rental of most medical devices, including diabetic-related supplies.
   - Most medical assistance tools for disabilities, such as seeing-eye dogs and text telephones for hearing impairments.

2. Dependent Care Account: Used for reimbursement for the care of your child or other tax dependent while you are at work; for reimbursement services at a dependent care center (the center must comply with all state and local laws).

   Specifications for using this account:
   - Your child must be age 12 or under and reside with you.
   - Your child or other dependent over the age of 12 must be incapable of self-support and must spend eight or more hours per day in your home.
   - The individual caring for your child (age 12 and under) or other dependent must not be a tax dependent.
   - Reimbursement cannot exceed $5,000 per year for single individuals or married couples filing tax returns jointly ($2,500 if married filing separately) or the earned income of you or your spouse, whichever is less.

NOTE:

If there is other insurance that has paid any portion of the claim you are requesting reimbursement on, you must submit the explanation of benefits from the other carrier/insurance company.