FSA Claim Form
(Debit Card Substantiation or Reimbursement)

DataPath Administrative Services

❒ Please check here if this is a new mailing or email address

Employer Name (Please Print) _____

Employee Last Name (Please Print) _____First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone (_____)_____ Work Phone (_____)_____

Employee Email Address (if any)_____

Please read the Reimbursement Account Rules and Claim Filing Instructions provided online before completing this claim. ***All information below must be completed.***

Medical Expense Claims

Debit Card Used in Transaction?	Date of Service	Patient Name	Relationship	Provider	Description of Service	Amount
❒ Yes ❒ No						$
❒ Yes ❒ No						$
❒ Yes ❒ No						$
❒ 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 Reimbursement

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses 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.

I understand that 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.

For fastest reimbursement, please file online, use the mobile app, or email to abbes@datapathadmin.com

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

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