TRI-STAR SYSTEMS

FSA CLAIM FORM

Health Care (HCRA)
Dependent Care (DCRA)
Reimbursement Accounts

Stop! *Efile* for *priority* processing @ www.tri-starsystems.com!
(Do NOT file claim forms when sending debit card support.)

EMPLOYER NAME:	

PART 1 - COMPLETE FOR ALL CLAIMS

Social Security Number or Account Number	Last Name	First Name	Middle Name/Initial

* Street or P. O. Box	* Phone Number

* City	* State Code	* Zip Code

* Email Address

** Complete the address, phone number, and email address sections only if recently changed. Go online at www.tri-starsystems.com to verify your information on file.*

PART 2 - DEPENDENT CARE (DCRA)

See *Provider Certification* below if Receipts are not attached

Dependent Name	Age	Service From Date	Service Thru Date	Provider Name	Provider TAX ID	Claimed Amount
					Total DCRA Claimed:	

DEPENDENT CARE *Provider Certification*

Complete this section if Dependent Care receipts are not attached.

I certify the information listed above, in PART 2, is correct.

Provider Name	Authorized Provider Signature	Date Signed

PART 3 - HEALTH CARE (HCRA)

See below for explanation of a VALID RECEIPT

Check the box if this claim is for substantiation of an FSA Debit Card Transaction ↓

Patient Name	Service Dates	Description of Service	Provider Name	Claimed Amount	☐
					☐
					☐
					☐
					☐
				Total HCRA Claimed:	

PART 4 - Acknowledgement and Signature

I certify that all services and expenses for which reimbursement is claimed by submission of this form were received by me or an eligible dependent. I certify the medical expenses claimed have not been reimbursed and will not be presented for reimbursement through any other health plan. I acknowledge I am responsible for any inappropriate use or disclosure of my information that occurs due to the method I have selected for transmitting this information. I understand that I alone am fully responsible for the accuracy of all information I have provided by submission of this claim form. I understand that by providing incomplete, false, or misleading information on this form that I may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan made in error.

Employee Signature	Date

VALID RECEIPT: Each claim must be supported by one of the following: a valid statement showing the charges incurred, the date incurred, name of patient, provider of services, reason for the service, and the amount charged, OR an Explanation of Benefits (E.O.B.) from your insurance company. If you are covered by insurance for the services provided you should submit those charges to the insurance company first and then send the E.O.B. to us. Claims received absent the above listed item(s) cannot be processed.

RETURN SIGNED AND DATED FORM WITH SUPPORTING DOCUMENTATION TO:

Tri-Star Systems
ATTN: FSA Claim Department
14323 South Outer 40 Road
Suite 200 South
Chesterfield, MO 63017-5734

PHONE (Cust Service) (314) 576-4022
TOLL FREE (Cust Service) (800) 727-0182
CLAIMS FAX (314) 985-0277
CLAIMS FAX (Toll Free) (800) 818-0829

Tri-Star Systems is a division of Tri-Star Benefit Systems, Inc. of Chesterfield, Missouri