Fax to:
MVP Health Care Flexible Benefit
(877) 780-6067
No Cover Page Required

FSA Claim Form – EASTMAN KODAK

Last Name, First Name, MI (Please Print) _____

Employer Group# 705000

Social Security Number or MVP Subscriber ID (EID) as appropriate _____

Street Address _____

City, State, Zip _____

Dependent Care Assistance (day care, babysitting, etc.)

Dependent care expenses must be for a dependent who is incapable of self care or under the age of 13 at the time the care was provided.

Name of Dependent	Age	Dates Care Provided		Name, Address, and Taxpayer Identification Number of Care Provider	Cost for Care Period	MVP use only
		From	To*			
		Total Dependent Care Amount Requested →				

I provided the dependent care as stated above. _____ _____ _____

Care Provider's **original** signature | Date | SSN/Tax ID#

***Claims for future services are not eligible for reimbursement.**

Unreimbursed Medical Benefits

Date Medical Care **Provided** **(Arrange documentation in same order)**	Name of Medical Provider	General Medical Expense Description. Include medical condition for over-the-counter items.	Patient Name	Relation-ship	Amount that is your responsibility	MVP use only
	Total Medical Amount Requested →					

Please submit a DETAILED STATEMENT OF SERVICES or INSURANCE EXPLANATION OF BENEFITS (EOB) statement for each expense you are claiming. Credit card receipts or statements with a previous balance are not sufficient documentation.

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any claimed Dependent Care Assistance expenses were provided for my dependent under the age of 13 or for my dependent who is incapable of self care. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature | Date

MVP Flexible Benefits Department
PO Box 2207
Schenectady N.Y. 12301

← Submit Form to MVP **ALONG WITH SUPPORTING DOCUMENTATION**
Fax (877) 780-6067

Claim Filing Requirements

1. ***Print your name, address, social security number or employee ID (EID) as appropriate and your employer's name.***

2. ***List expenses by date & arrange the supporting statements in the same order.*** Please circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
   - Day care claims - complete the Dependent Care Assistance section
   - Health care claims - complete the Unreimbursed Medical Benefits section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).

3. ***Enclose required documentation**.*** A written statement from the dependent care or medical (Dr., hospital, pharmacy, etc.) provider of the service or an insurance company benefits statement showing all of the following:
   - The name of the dependent care or medical service provider,
   - The date or range of dates of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
   - A description of the service provided (for example, for health care, "dental cleaning", or for day care "day care"),
   - The name of the person or persons receiving the medical or dependent care, and
   - The cost of the service, not just the amount paid.

   ***Dependent Care claims only.** - You may either provide documentation from the day care provider or have the provider complete the Dependent Care Assistance Section, then sign on the "Provider's Signature" line and date the signature. You do not need to do both.

   Requests filed without the above documentation cannot be processed and will be returned.

4. ***Sign*** the claim form.

5. ***Keep*** copies for your tax records.

6. ***Mail*** to the address on the front of this form, submit the claim online, or ***Fax to (877) 780-6067***. This is not a toll free number, emploree use of an office fax machine may not be appropriate. Please check with your employer before using an office fax machine.

The website for online claims submission is www.mywealthcareonline.com/MVPHealthCare. **You may also e-mail claims with your supporting documentation to** *myspendingaccounts@mvphealthcare.com*

Over-the-counter medicines & drugs: Additional filing requirements for plans allowing these under the medical FSA:

- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- To claim vitamins, herbs or nutritional supplements, you must have a written diagnosis of the medical condition and "prescription" of all specific items for that condition on file with the claims office. You must renew this physician notice every 12 months and file it with the claims office with the first claim submitted for those items each plan year.

Orthodontics: Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. Pre-payments are not allowed. You must submit a written statement from the orthodontist showing the charge for the initial installation work, when it was completed and a paid receipt to claim an initial down payment or appliance fee.

Medical equipment: Requires a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed and that the equipment is essential to the treatment.

Claims payment and account information available 24 hours a day 7 days a week: - Complete history including available funds online at www.mywealthcareonline.com/MVPHealthCare.

Claim forms: You may copy this form or obtain forms online at www.mywealthcareonline.com/MVPHealthCare

Resources

Customer Service:	*(877)637-5620*	***Claims Fax:***	*(877) 780-6067*
Customer Service Email:	*myspendingaccounts@mvphealthcare.com*		
Claims mailing address:	***MVP Flexible Benefits, P.O. Box 2207 Schenectady N.Y. 12301***		