Texas Educator Benefits
Medical Flexible Spending Account Claim Form

Remit To:
Texas Educator Benefits
FSA Claim Processing
702 Wyoming Ave
El Paso, TX 79902
FAX: 915-532-1426
EMAIL: claims@teb-inc.com

Employee Information

Employer Name:		Daytime Phone:	
Employee Name:		SSN #:	
Employee Address:		Apt/Suite:	

City:		State:		Zip:		E-Mail:	

PLEASE NOTE: Claims that are not listed on this form cannot be processed. You must complete each field below for each claim you are seeking reimbursement for and attached supporting documentation.

Unreimbursed Medical Expenses *(Attach supporting documentation)*

Supporting documentation for unreimbursed medical expenses must include all of the following:

- ☐ Provider's name and address
- ☐ Service Description
- ☐ Date of Service
- ☐ Patients name
- ☐ Amount Billed

Date of Service	Apply to Plan Year: Current / Previous?	Person for Whom Expense was Incurred	Name of Service Provider	Description of Services	Amount

Calculate Total — Total Amount Requested:

Employee Confirmation

I certify that the claims listed above are a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under the Flexible Spending Account(s). Supporting documentation from my service provider(s) for all expenses is attached to this claim form. I understand that I cannot claim any reimbursed expenses from the plan on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of the Flexible Spending Account(s).

Employee's Signature: _____ **Date Signed (mm-dd-yyyy):** _____

Internal Use Only: **Date Received:** _____ **Date Entered:** _____