Request for Health FSA Reimbursement – Claim Form

☐ Please check here if new mailing address ☐ Please check here if new email address

Employer Name (Please Print) **State of Arkansas**

Employee Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

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

Employee Email Address _____

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

Debit Card Purchase?	Service Date (mm/dd/yyyy)	Patient Name & Relationship	Provider Name & Address	Description of Service	Amount
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
☐ Yes ☐ No					$
				Total	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, 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.

Employee's Signature _____ Date ___/___/___
mm/dd/yy

DataPath Administrative Services, Inc.
1601 Westpark Drive • Suite 9 • Little Rock, AR 72204 • 501-687-6954 • Toll-Free 877-685-0655
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For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP