MRP & DCP CLAIM REIMBURSEMENT FORM

EMPLOYER **BAY CITY ISD** PLAN YEAR **9-1-2016 / 8-31-2017**

EMPLOYEE NAME _____ SSN _____ CELL _____ WORK _____

HOME ADDRESS _____ E-MAIL (*PERSONAL IS PREFERRED*) _____

New Address-YN [ ] NUMBER & STREET CITY ST ZIP

INSTRUCTIONS AND REQUIREMENTS FOR REIMBURSEMENT

MRP & DCP CLAIM SUBMISSION DEADLINE IS: 11-29-2017

- Complete all required information on this Form. Sign and date the Form. Attach supporting documentation as appropriate. Use this Form only for expenses incurred for the Plan Year shown above.
- *The IRS does not allow payment receipts, check copies, charge slips, balance forward or previous balance statements as acceptable documentation.* ***Proof of payment is not required.***
- Plan Administrator is *National Family Care*. Fax (preferred) **888.868.1826** -or- Mail to: NFC Café Admin • 13530 Inwood Road • Dallas, TX 75244. If mailing, keep originals as documentation will not be returned.
- Reimbursement is made through **Direct Deposit (ACH)**. NFC must have your Bank information to process Manual Claims. Contact NFC for assistance.

MEDICAL REIMBURSEMENT PLAN CLAIMS (MRP)

This Plan has a GRACE PERIOD, which extends thru 11-14-2017 ... Read the Grace Period Notice below.

GRACE PERIOD NOTICE: Any unused benefits remaining on the last day of the Plan Year may be used for Qualifying Medical Care Expenses that are incurred during the Grace Period that shall expire upon the earlier of (1) The date you cease being an active Participant; or (2) 75 days following the end of the Plan Year noted above, or 11-14-2017. You have an additional 15 days to submit claims, or 11-29-2017.
***For Grace Period expenses, you must pay for the expense yourself and then submit a Manual Claim Form to NFC for processing*. Use this Form.**

- **Medical Expense Support Documentation Must Include**: ***Date of Service*** (Not Date Paid), ***Patient Name, Amount of Charges, Provider Name & Address, Expense Incurred*** (Type of Service).
  We recommend submitting your claims to your health plan first, then submit a copy of the Explanation of Benefits (EOB) containing all the documentation noted above.
- ***PRESCRIPTION*** co-pays, submit the co-pay receipt containing: *Patient Name, Drug's Name, Date the prescription was filled,* and co-pay *Amount*. Cash register prescription or charge receipts cannot be accepted.
- ***ORTHODONTIA*** expenses, submit the contract itemizing the treatment period, down payment, monthly payment amounts and amount covered by insurance. Only current services are reimbursable.
- ***Over-the-counter (OTC)*** *drug claims* must include a **Physician's Note** used to obtain such drug and a *receipt* indicating: *Drug's Name* (abbrev. must be recognizable), *Date of Purchase, Amount of Expense* and *Merchant Name*.
- Additional Items: Allowable medical expenses include Total Charges less Insurance Reimbursement. Cosmetic Surgery is NOT allowed. Support must designate *Date of Service* – date the expense was incurred, not paid.

Date of Service (Start Date)	(End Date)	Expenses For: Patient Name	Relation / DOB – if child	Type of Service (i.e., med, dental, vision, RX)	OVER-THE-COUNTER (OTC) DRUGS W/PRESCRIPTION: Drug Name	Medical Condition	Reimbursement Requested
					Total Amount Requested →		$

DEPENDENT CARE PLAN CLAIMS (DCP) – CHILD CARE EXPENSES

This Plan has no Grace Period.

No Grace Period applies. Qualified events must occur within the Plan Year and claims must be submitted within **90** days after the end of the Plan Year, or 11-29-2017. You may submit DCP claims under either of the two methods: **(1)** Complete this Claim Reimbursement Form and have the Care Provider sign and date it; or **(2)** Complete this Claim Reimbursement Form and *attach* support documentation including: *Care Provider Name and Address*, *Dependent Name(s), Dates of Service*, and *Amount of Expense*. You may only be reimbursed up to the amount withheld at any point through the Plan Year. Documentation for camps must show that it is only for a **day** camp.

Date of Service (Start Date)	(End Date)	Dependent Name	Relationship	Age	Name Of Care Provider & Tax ID (or SSN)	Reimbursement Requested
					Total Amount Requested →	$

I certify that I provided dependent care as reported above.

Dependent Care Provider Signature **(ONLY WHEN A RECEIPT IS NOT PROVIDED)** _____ Date _____

I certify that:

1. Expenses listed above have been incurred by me or my eligible dependents during this Plan Year.
2. Expenses were incurred during the time period which contributions were being received by the Plan.
3. All applicable insurance or other health plan benefits have been exhausted.
4. I am liable for taxes (Federal, State or City) or penalties arising out of any disallowed deductions.
5. I will not deduct these reimbursements or take them as a tax credit on my Federal Income Tax Return.
6. A prescription was obtained for all over-the-counter (OTC) drugs listed (other than insulin).

Employee Signature (Required) _____ Date _____

NFC Café Admin • 13530 Inwood Road • Dallas, TX 75244

Fax 888.868.1826 • 800.527.0996

EXHIBIT 5–1

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