1605 Associates Drive
Suite 101
Dubuque, IA 52002
Phone: (563) 584-4853
Toll-free: 866-682-2993
Fax: (563) 556-5134
FlexProcessing@mahealthcare.com

DEBIT CARD SUBSTANTIATION

Employee:_____ Email Address:_____

Employee SSN#:_____ Employer:_____

For each of the accounts, please include documentation in the order you have listed and attach to this claim form.
NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation.

Health FSA

Date(s) of Service	Description of debit card expense (i.e., eye exam)	Dollar Amount
1.		$
2.		$
3.		$
4.		$
5.		$
		$

READ CAREFULLY AND SIGN: I understand if I am requesting reimbursement from my reimbursement account(s) for the expenses itemized above, I make the following certification: I certify that the expenses for which reimbursement is requested under the reimbursement account(s) were for services received either by myself or my eligible dependent(s). I also certify that I or my eligible dependent(s) have received services described on the dates indicated, and these are my out-of-pocket expenses that qualify as valid expenses under the plan(s) and the Internal Revenue Code. I certify that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan. I also certify that any medically related expenses itemized above are to diagnose, alleviate, or prevent a medical condition and not merely beneficial to general health. If this claim is for medical expenses, I understand that if I, my spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else, I must have a Limited Purpose or Post Deductible Medical Reimbursement Account (Health FSA) or a Limited Purpose, Post Deductible, Suspended, or Retirement Health Reimbursement Arrangement (HRA). I further understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. I understand that I alone 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(s), I may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan(s) which relate to such expense. This certification also applies to any Flex Debit Card payments for which receipts are included for items listed above.

Employee Signature:_____ **Date**_____