CITY OF ST. PAUL
MEDICAL, DEPENDENT CARE AND/OR HRA EXPENSE REIMBURSEMENT ACCOUNT
REIMBURSEMENT REQUEST FORM

Name	Employee ID	**Submit claims to:** CieloStar 730 Second Ave. So. - Suite 530 Minneapolis, MN 55402 Phone 612-436-2778 Toll-free 877-491-5979 Toll-free fax: 877-491-6016 Local fax 612-335-9217 Email: flex@cielostar.com
Home Address	Address Change ☐ Yes ☐ No	
City	State / Zip	
Phone: Work Home	e-mail:	

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. Dependent children from age 19 and under age 26 must be tax dependents in order to claim their expenses on your HRA/FSA account, even if they are covered on your medical insurance. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete it will be returned to you. Print or type the information requested, then sign and date the form. Mail or fax this form and supporting documentation to CieloStar.

FSA/HRA
MEDICAL EXPENSES (Medical, Dental, Vision)

	Provider of Service (Doctor, dentist, pharmacy, etc.)	Person Receiving Service (self, spouse, child)	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1				$	
2				$	
3				$	

DCRA
DEPENDENT CARE EXPENSES

	Provider of Service	Person Receiving Service (Dependent's name)	Age of Dependent	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Provider Tax I.D. Number (Social Security Number if Individual)
1					$	
2					$	
3					$	

Dependent Care Provider's Signature (if individual)_____

I hereby request reimbursement from my applicable flexible spending account(s)/HRA, pursuant to the plan and applicable law, for the expenses listed above. I hereby represent and certify that the above expenses have actually been incurred by me and that these expenses have not and will not be reimbursed by any benefit plan and will not be claimed as an itemized income tax deduction.

Employee Signature_____Date_____

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS

Revised 5/8/2015

INSTRUCTIONS FOR COMPLETION OF HRA/FLEXIBLE SPENDING CLAIM FORMS

HCRA/HRA

HEALTH CARE EXPENSES (Medical, Dental, Vision)

- Complete claim form – all requested information must be provided or claim will be denied.
- Attach originals or copies of medical bills, insurance explanation of benefits, prescription drug receipts, cash register receipts, etc. The documentation must provide the following information or the claim will be denied:
    1. Name of provider of service (doctor, dentist, pharmacy, etc.)
    2. Name of person receiving service (self, spouse, dependent)
    3. Date of service
    4. Explanation of procedure
    5. Cost of procedure less any amounts paid by primary insurance provider
- Mail or fax claim and expense documentation to:

  CieloStar
  730 Second Ave. So., Suite 530
  Minneapolis, MN 55402
  Fax (877) 491-6016
  Or (612) 335-9217
  flex@cielostar.com

DCRA

DEPENDENT DAY CARE EXPENSES

- Complete claim form – all requested information must be provided or claims will be denied.
- Attach originals or copies of daycare invoices or payment receipts issued by daycare provider. The documentation must provide the following information or the claim will be denied:
    1. Name of daycare provider
    2. Tax ID number or social security number of provider
    3. Name of dependent receiving daycare service
    4. Dates of service
    5. Cost of service
- Mail or fax claim and expense documentation to:

  CieloStar
  730 Second Ave. So., Suite 530
  Minneapolis, MN 55402
  Fax (877) 491-6016
  Or (612) 335-9217
  flex@cielostar.com

Claims are processed in a timely manner.