BAYSTATE BENEFIT SERVICES

Cafeteria Plan CLAIM FORM

Health FSA/Dependent Care
QTE Transit/Parking

Employer Name:	Employee Name:
Employee Address:	Employee Day Phone Number:
City: State: Zip: ☐ Check if new address	Employee Email Address:

CLAIM DETAIL
***Services: Day Care (DC) - Medical (M) - Office Visit (OV) - Prescription (Rx) Over-the-Counter (OTC) - Dental (D) - Vision (V) - Transit (T) - Parking (P)**

Date of Service:	Who received service:	*Type of Service:	Amount:
		☐DC ☐M ☐OV ☐Rx ☐OTC ☐D ☐V ☐T ☐P	
		☐DC ☐M ☐OV ☐Rx ☐OTC ☐D ☐V ☐T ☐P	
		☐DC ☐M ☐OV ☐Rx ☐OTC ☐D ☐V ☐T ☐P	
		☐DC ☐M ☐OV ☐Rx ☐OTC ☐D ☐V ☐T ☐P	
		☐DC ☐M ☐OV ☐Rx ☐OTC ☐D ☐V ☐T ☐P	
		☐DC ☐M ☐OV ☐Rx ☐OTC ☐D ☐V ☐T ☐P	
		TOTAL:	

Day Care Provider's Tax ID or SSN:	Day Care Provider's Name:

I understand that if I claim these expenses here, that I may not claim the same expenses elsewhere, either as tax credit or tax deduction.

I certify that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse and to Baystate Benefit Services using the above email address for communication regarding my claim information.

Participant Signature: ______________________________ Date: ______________

Completed forms and all required receipts may be faxed, emailed or mailed to:
Baystate Benefit Services, Inc., 400 Washington St., Suite 400, Braintree, MA 02184
Tel: (800)601-3570 Fax: (781)356-7365 Email: 125@baystatebenefits.com
You may also upload your claims and applicable receipts at www.baystatebenefits.com, click on "Employee Portal" and "File a Claim".