PLEASE DO NOT STAPLE

LPFSA CLAIM FORM

Limited Purpose Health Care (HCRL) Reimbursement Account

For *priority* processing, Login to your account and file online!

Go to www.tri-starsystems.com and select "Participant Login."

EMPLOYER NAME:	

PART 1 - COMPLETE FOR ALL CLAIMS

Social Security Number or Account Number	Last Name	First Name	Middle Name/Initial

* Street or P. O. Box	* Phone Number

* City	* State Code	* Zip Code

* Email Address

** Complete the address, phone number, and email address sections only if recently changed. Go online at www.tri-starsystems.com to verify your information on file.*

PART 3 - LIMITED PURPOSE HEALTH CARE (HCRL)

See below for explanation of a VALID RECEIPT

Tri-Star Use Only (Limited to Only Dental or Vision Expenses)

Patient Name	Service Dates	Description of Service	Provider Name	Claimed Amount
			Total HCRL Claimed:	$ 0.00

PART 4 - Acknowledgement and Signature

I certify that all services and expenses for which reimbursement is claimed by submission of this form were received by me or an eligible dependent. I certify the medical expenses claimed have not been reimbursed and will not be presented for reimbursement through any other health plan. I acknowledge I am responsible for any inappropriate use or disclosure of my information that occurs due to the method I have selected for transmitting this information. I understand that I alone am fully responsible for the accuracy of all information I have provided by submission of this claim form. I understand that by providing

Employee Signature	Date

VALID RECEIPT: Each claim must be supported by one of the following: a valid statement showing the charges incurred, the date incurred, name of patient, provider of services, reason for the service, and the amount charged, OR an Explanation of Benefits (E.O.B.) from your insurance company. If you are covered by insurance for the services provided you should submit those charges to the insurance company first and then send the E.O.B. to us. Claims received absent the above listed item(s) cannot be processed.

RETURN SIGNED AND DATED FORM WITH SUPPORTING DOCUMENTATION TO:

Tri-Star Systems
ATTN: FSA Claim Department
16401 Swingley Ridge Road
Suite 250
Chesterfield, MO 63017-5734

PHONE (Cust Service) (314) 576-4022
TOLL FREE (Cust Service) (800) 727-0182
CLAIMS FAX (Toll Free) (800) 818-0829

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