WA STATE PEBB
FLEXIBLE SPENDING ARRANGEMENT (FSA) & DCAP CLAIM FORM

FOR PLAN YEAR JANUARY 1, 2024 through DECEMBER 31, 2024
Submit all 2024 Medical FSA, Limited Purpose FSA, and DCAP claims to Navia Benefit Solutions by March 31, 2025*

Instructions

1. Use this form only for services that occur during the year shown above. **Do not use this form for debit card transactions**.
2. **Do not staple any documentation to claim form.** Please tape to separate sheet or include loosely in envelope. **Do not send originals.** All claims are stored electronically, and paper copies will be shredded.
3. Complete Section II for DCAP claims. Attach day care claim documentation showing the dates of service, types of service, cost of service, dependent's name, and provider's name and tax ID or Social Security number (no cancelled checks, balance forwards, or bank card receipts).
4. Complete Section III for Medical FSA or Limited Purpose FSA claims. Attach claims documentation showing the dates of service, types of service, and cost (no cancelled checks, balance forwards, or bank card receipts). Itemize all expenses to prevent delays in reimbursement.
5. Sign the claim form. Fax, email or mail your signed form using the contact information below. You can go to pebb.naviabenefits.com to view the status of your claim.

Section I – Employee Information

Last Name, First Name MI		Day Phone	SSN (Employee ID if higher education)
Address	City State	ZIP/Postal code	Email - See information in Section IV
☐ **Address Change**			

Section II – DCAP Claims Claims for future services will not be accepted.

Start Date	End Date	Provider's Name, Address, Tax ID or SSN	Name of Dependent	Age	Cost for care period
Provider's Signature and Date					
See IRC Section 129 for qualifying day care expenses or consult your tax advisor for more information.			**Total Request $**		

Section III – Medical FSA or Limited Purpose FSA Claims

Service Dates	Type of Service (Give general description)	Name of Provider	Self/Dependent	Net Cost	Is this replacing a previous ineligible debit card charge? (Y/N)
Did you use your debit card for any of these expenses? ❑ **No** ❑ **Yes**					
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			**Total Request $**		

Section IV – Signature

To the best of my knowledge, my statements on this claim form are complete and true. I understand it is my responsibility to ensure this claim from my Medical FSA, Limited Purpose FSA, or DCAP account and all information related to this claim is complete, accurate, and truthful. I understand I may be liable for the payment of all related taxes including federal income tax for an ineligible expense paid from the account. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. Any health care reimbursement claims are for eligible medical care expenses incurred by myself, spouse, or dependents during the plan year shown above. I certify that these expenses have not been reimbursed under this plan or by any other source, and that they will not be reimbursed by any other source or insurance. By providing an email address, I agree to receive all communications about this benefit via email. I may withdraw consent at any time without charge by contacting Navia Benefit Solutions by phone, email, or mail. I authorize my Medical FSA, Limited Purpose FSA, or DCAP account to be reduced by the amount(s) shown above.

Participant's Signature:	Date:

Forms and supporting documentation can be faxed, emailed, or mailed to: (425) 451-7002 or toll-free (866) 535-9227, claims@naviabenefits.com or Navia Benefit Solutions PO Box 53250 Bellevue, WA 98015-3250
Customer Service: (800) 669-3539. Visit our website at pebb.naviabenefits.com