FSA Repayment Form

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- You may need to pay back part or all of a claim reimbursement or benefits card purchase if later you find that (1) the claim was or should have been reimbursed from another source; (2) your actual out-of-pocket amount was less than the reimbursement amounts your received; or (3) your benefits card purchase was a non-qualified expense.
- Mail completed forms and check to: **OneBridge FSA, PO Box 4391 Clinton, IA 52733-4391.**
- For questions, contact us at: **1-888-338-4415**.

Section 1: Participant Information (Please fill out your benefit information below.)

Participant Number or SSN:		Date of Birth:
Name:		
Address:		Is this a new address? ☐
City:	State:	Zip Code:
Phone Number:		Email:

Section 2: Medical Information

- Make check payment to: **OneBridge FSA**.
- List each expense you are repaying in the table below.
- Provide the check number and amount.
- Mail your check and this completed form to: **OneBridge FSA, PO Box 1246, Spokane WA 99210**.

Repayment Information

Claim Number or Card Transaction ID	Date of Service/Transaction	Amount Repaid	Reason

Enclosed Check Number:	Enclosed Check Amount: $ 0.00

Authorization (signature required)

I acknowledge and certify that:

- The claim reimbursement or benefits card purchase amount being paid back should not have been disbursed from my FSA.
- I have, and can provide upon request, supporting documentation that I should not have received the claim amount being paid back (e.g. revised explanation of benefits (EOB), statement showing ineligible expense, etc.)

Participant Signature: _____ Date: _____