FSA Account
Reimbursement Request Form

Participant Information	To Update your information, log on to your account at www.basiconline.com/account_access

Employer: _____

Name: _____ Participant ID #:_____

How to Submit for Reimbursement

CDA Portal: Skip this form and visit https://cda.basiconline.com/. Select Request a Reimbursement, follow the prompts and upload documentation.

Secure Upload: Visit https://claims.basiconline.com/Portal.aspx and upload this form and documentation.

Fax this form and documentation to 269-327-0716

Mail this form and documentation to BASIC CDA Dept. PO Box 6278, Monona, WI 53716

Required medical documentation:

- BEST: Explanation of Benefits (EOB) from the insurance carrier.
- ALTERNATIVE: Documents that show the date of service, description of service or purchased items, amount paid, and provider's name and address.

Signature of Day Care Provider: _____

Your provider may sign this form on the line above or provide a receipt for services.

Itemized Medical & Dependent Care Expenses

Benefit Card used for this expense [please check yes or no]		Medical or Day Care Expense [please check expense type]		Date(s) of Service [provide the date or date range which service(s) were provided]	Service Provider [The name of the provider who provided the service]	Amount [Enter the reimbursement amount requested]
Yes	No	Medical	Day Care			$
Yes	No	Medical	Day Care			$
Yes	No	Medical	Day Care			$
Yes	No	Medical	Day Care			$
Yes	No	Medical	Day Care			$

I certify that I have not already been paid for these expenses from my Medical/Dependent Care Plan or any other source. I have submitted the above information in good faith, and it is correct to the best of my knowledge. I understand that reimbursement is not a guarantee. The service for which I am requesting reimbursement must be incurred during my period of participation. Services incurred after participation ends are not eligible for reimbursement even if there was a balance remaining in my account.

Signature: _____ Date: _____