

# HCFSA Procedures Guide

New York City | Flexible Spending Accounts Program



## *Your Welcome Kit Includes*

- ~ Important Website Information
- ~ How to Submit HCFSA Claims
- ~ Instructions for Submitting Claims During 2020 Grace Period
- ~ Claims and Reimbursement Procedures
- ~ Monthly Claims Payment and Quarterly Statements
- ~ Over-the-Counter (OTC) Drug Claims (with prescription only)
- ~ HCFSA Claims Form
- ~ Medical Necessity Form
- ~ HCFSA Program HIPAA PHI Authorization Form

Plan Year  
**2020**

**FSA**

***Please visit the  
Flexible Spending Accounts (FSA) Program  
Website at [nyc.gov/fsa](https://nyc.gov/fsa)  
for detailed information on:***

- The Dependent Care Assistance Program (DeCAP)
- The Health Care Flexible Spending Account (HCFSA) Program
- The MSC Health Benefits Buy-Out Waiver Program
- The MSC Premium Conversion Program

***You can select Forms & Downloads for:***

- Plan Year 2020 Brochures and Enrollment/Change Forms
- FSA Program Claims Forms
- Medical Necessity Form
- HCFSA Program HIPAA PHI Authorization Form
- FSA Direct Deposit Enrollment/Change/Cancellation Form

# How to Submit HCFSA Claims

**Plan Year and Grace Period:** You may file claims from January 1, 2020 through December 31, 2020 for Plan Year 2020. You may also submit claims incurred during the Grace Period (January 1, 2021 through March 15, 2021) using the remaining balance in your Plan Year 2019 account, if any.

**Claims Run-Out Period:** If you need time to obtain additional documentation from your health plan(s) and/or Welfare Fund(s) for claims incurred during Plan Year 2020 or the Grace Period, you may file claims from January 1, 2021 through May 31, 2021. The last day to submit all claims is May 31, 2021.

## Medical Claims

- #1 - Submit all medical claims to your primary health plan
- ↓
- #2 - Submit remaining expenses to your secondary health plan or Welfare Fund's Superimposed Major Medical Plan (if applicable)
- ↓
- #3 - Obtain Explanation of Benefits Statements (EOBs) from both primary and secondary health plans
- ↓
- #4 - Complete an HCFSA Claims Form for remaining expenses and submit it along with your EOBs

## Over-the-Counter (OTC) Drug Claims (with prescription only)

- #1 - Follow the checklist on the OTC drug claims instruction sheet enclosed in the HCFSA Procedures Guide to determine whether the product is eligible for reimbursement
- ↓
- #2 - Compile copies of doctor's prescriptions and itemized receipts from OTC drug purchases and indicate recipient's name on OTC receipt
- ↓
- #3 - Make copies of product boxes if receipts do not indicate which OTC drugs you purchased
- ↓
- #4 - Complete an HCFSA Claims Form and submit it with your receipts and doctor's prescription

## Office Visit Co-Pays and Prescription Drug Co-Pays

- #1 - Compile receipts (or EOBs) indicating your co-pays
- ↓
- #2 - Complete an HCFSA Claims Form and submit it along with your EOBs or receipts

## Dental and Vision Care Claims

- #1 - Submit all dental and vision care claims to your union or Welfare Fund
- ↓
- #2 - Obtain EOBs from your union or Welfare Fund
- ↓
- #3 - Complete an HCFSA Claims Form for remaining out-of-pocket expenses and submit it along with your EOBs

## Hearing Aid Claims

- #1 - Submit all hearing aid claims to your union or Welfare Fund's secondary health plan such as a Superimposed Major Medical Plan (if applicable)
- ↓
- #2 - Obtain EOBs from your union or Welfare Fund's secondary health plan such as a Superimposed Major Medical Plan (if applicable)
- ↓
- #3 - Complete an HCFSA Claims Form for remaining out-of-pocket expenses and submit it along with your EOBs

# ***Instructions for Submitting Claims During 2019 HCFSA Grace Period***

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## ***What is the HCFSA Grace Period?***

Previously, under the “Use It or Lose It” Rule mandated by the IRS, any amount contributed to your HCFSA but not claimed by the end of the Plan Year was forfeited. Now the IRS permits a Grace Period, which is an additional time period during which you may submit claims for eligible medical services received from January 1 through March 15 following the end of the Plan Year if you have a remaining balance in your previous Plan Year’s account. The Grace Period affords you an opportunity to use any remaining funds without having to forfeit your entire balance after the last day of the Plan Year.

The Grace Period during which you may use your remaining balance in your Plan Year 2020 account is from January 1, 2021 through March 15, 2021. (NOTE: The Claims Run-Out Period described below also applies to claims submitted during the Grace Period).

## ***What is the Difference Between the Grace Period and Claims Run-Out Period?***

The Claims Run-Out Period, which runs from January 1, 2021 through May 31, 2021 is an additional time period during which you may submit outstanding or pending claims for services received during Plan Year 2020 or Grace Period 2019.

### ***For example:***

You received a medical service during Plan Year 2020, but did not receive an Explanation of Benefits (EOB) prior to the last day of the Plan Year (December 31, 2020) in order to submit a claim on time. You will have until the last day of the Claims Run-Out Period (May 31, 2021) to obtain your EOB and submit your claim.

You received a medical service during Grace Period 2019, but did not receive an EOB prior to the last day of Grace Period 2020 (March 15, 2021) in order to submit a claim on time. You will have until the last day of the Claims Run-Out Period (May 31, 2021) to obtain your EOB and submit your claim.

## ***What Happens to My Remaining Balance from Plan Year 2019 if I Do Not Submit a Claim by May 31, 2021?***

According to the IRS, if you do not submit a claim incurred during Plan Year 2020 or Grace Period 2020 by May 31, 2021, any amount remaining in your Plan Year 2020 account will be forfeited.

# Health Care Flexible Spending Account (HCFSA) Program Claims and Reimbursement Procedures

Please follow these procedures for the expedient processing of your claims and note that medical care must be for expenses to diagnose, cure, mitigate, treat or prevent disease or to affect any structure or function of the human body.

1. Submit your Claims Forms once a month, on or before the last day of the month. (Minimum reimbursement amount requested must total \$50.00 unless current account balance is less than \$50.00).
2. Attach the following documentation to Claims Forms:
  - Itemized bill or receipt from service provider, and
  - Explanation of Benefits (EOB) statement (issued by your health insurance carrier for medical expenses or Welfare Fund for dental, vision and/or hearing expenses, indicating benefits received and services for which payment has been requested)
  - Copy of product box for over-the-counter (OTC) drugs if receipt does not indicate name of the drug, and doctor's prescription.
3. Each EOB, bill, receipt, and Claims Form must contain the following information:
  - Name of patient receiving service
  - Type of service
  - Date of service
  - Amount of charge for service
  - Name of provider rendering service

Note: The date(s) of service(s) on the Claims Form must match the date(s) of service(s) on the EOB and the receipt or billing statement.

To obtain an EOB for medical, dental, vision, or hearing expenses, deductibles, or co-payments covered by any group health plan, you must first submit your expenses to your health insurance carrier and/or Welfare Fund. The health insurance carrier and/or Welfare Fund will send you an EOB stating what amount, if any, is covered by your health plan and/or Welfare Fund.

Please be advised that even if you know an incurred health care expense is not covered by your health insurance carrier and/or Welfare Fund, you still need to submit the claim first to your health insurance carrier and/or Welfare Fund to receive an EOB from them stating that your claim is not covered. In a situation where an EOB cannot be obtained, you may submit to our office, in lieu of the EOB statement, a copy of your health insurance and/or Welfare Fund Plan Document stating that the health care expense is not covered by your health insurance carrier and/or Welfare Fund.

If you have any further questions regarding your HCFSA claims, please call the HCFSA Administrative Office at (212) 306-7760.

Note: This instruction sheet was formulated to assist you in the submission of your claims. Please refer to this sheet throughout the Plan Year.

# Health Care Flexible Spending Account (HCFSA) Program Claims Payments and Quarterly Statements

## Monthly Claims Payment Statement

If claims are submitted and approved by the last day of each month, you will receive reimbursement by the end of the following month. At the end of each month, you will receive a monthly claims payment statement indicating claims processed for that month and amount of reimbursement issued.

The dollar amount of a claim that exceeds your annual benefit amount will not be paid and will be listed under "Amount Unpaid." Your available balance is equal to the amount you elected to contribute to the program, less the annual administrative fee and the total amount of claims paid from your account.

The year-to-date summary details your account activity. The following is an explanation of terms used:

Annual Election:	total yearly amount you elect to contribute to the program
Administrative Fee*:	up to \$4.00 monthly, up to \$48.00 annually
Benefit Amount:	your annual election less the up to \$48.00 annual administrative fee
Claims Submitted:	total amount of all claims submitted
Available Balance:	your benefit amount less the amount of claims paid
Amount Unpaid:	the dollar amount of claims submitted which exceeds the benefit amount
* The annual administrative fee may be adjusted by the FSA Administrator, but will not be greater than \$48 per program.	

## Quarterly Statement

In addition to the information on your monthly claims payment statement, every calendar year quarter you will also receive a statement detailing all of your account activity, regardless of whether any claims were submitted for reimbursement during the quarter.

The following is an explanation of terms used:

Annual Election:	total yearly amount you elect to contribute to the program
Administrative Fee*:	up to \$4.00 monthly, up to \$48.00 annually
Benefit Amount:	your annual election less the up to \$48.00 annual administrative fee
Amount Reimbursed to Date:	total amount of all claims paid
Available Balance:	your benefit amount less the amount of all claims paid
Deposits:	total amount of contributions to the program in a given month (Note: Activity during the last pay period of the reported quarter may not appear until your next statement.)
Claims Submitted:	total amount of all claims submitted
Claims Paid:	total amount reimbursed to date from your account
Amount Unpaid:	the dollar amount of claims submitted which exceeds the benefit amount
* The annual administrative fee may be adjusted by the FSA Administrator, but will not be greater than \$48 per program.	

**Note:** This instruction sheet was formulated to assist you in the reading of your monthly claims payment and quarterly statements. Please refer to this sheet throughout the Plan Year.

# Health Care Flexible Spending Account (HCFSA) Program

## Over-the-Counter (OTC) Drug Claims (with prescription only)

Please follow these procedures for submitting claims for OTC drugs (with doctor's prescription only):

1. Submit your Claims Forms once a month, on or before the last day of the month. (Minimum reimbursement amount requested must total \$50.00 unless current account balance is less than \$50.00).
2. Attach 3<sup>rd</sup> Party Receipt (not handwritten or printed by participant or recipient), which includes:
  - Name of drug;
  - Date the drug was purchased; and
  - Amount paid for the drug.
3. In the event that the receipt from the store in which the item was purchased does not specify the information listed in item number 2 above, you must submit, along with your receipt and Claims Form, additional documentation with identifying information that includes all of the information listed in item number 2. For example, you can include a photocopy of the original packaging (i.e., product box) bearing the product's name and/or the price tag on the package. For certain purchases, the Plan Administrator may require further documentation from your physician.
4. Attach copy of doctor's prescription.  
Examples of items that are ineligible for reimbursement include:
  - Alternative medicines;
  - Cosmetics;
  - Dietary supplements;
  - Toiletries;
  - Vitamins;
  - Items that are used for your general well-being; and
  - Any OTC drug without a doctor's prescription.
5. OTC drugs must be directly related to the diagnosis, cure, mitigation, prevention or treatment of an illness or medical condition.

**Note:** Not all OTC drugs are eligible for reimbursement. Please refer to the checklist below to see if your purchase qualifies.

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Is the purchase considered a drug or medical supply?



- If the answer is NO, you will not be reimbursed.
- If the answer is YES, answer the remaining questions:

If the purchase is a drug, did you receive a prescription from your doctor?



- If the answer is NO, you will not be reimbursed.
- If the answer is YES, answer the remaining questions:

Is the purchase merely beneficial to your general health?



- If the answer is YES, you will not be reimbursed.
- If the answer is NO, answer the remaining questions:

Is this drug or medical supply necessary for the treatment of disease or for the purposes of affecting any structure or function of the body?



- If the answer is YES, you will be reimbursed.
- If the answer is NO, answer the remaining questions:

Is this drug or medical supply necessary for the diagnosis or cure of disease or for the purposes of affecting any structure or function of the body?



- If the answer is YES, you will be reimbursed.
- If the answer is NO, answer the remaining question:

Is this drug or medical supply necessary for the mitigation (improvement) of disease or for the purposes of affecting any structure or function of the body?



- If the answer is YES, you will be reimbursed.
- If the answer is NO, you will not be reimbursed for this OTC purchase.

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**Note:** This instruction sheet was formulated to assist you in the submission of your claims. Please refer to this sheet throughout the Plan Year.

**Health Care Flexible Spending Account (HCFSA) Program**

**2) EMPLOYEE (PARTICIPANT) INFORMATION (PLEASE TYPE OR PRINT CLEARLY)**

LAST NAME	FIRST NAME	MI.	SOCIAL SECURITY NUMBER
HOME ADDRESS - NUMBER AND STREET <input type="checkbox"/> CHECK HERE IF THIS IS A NEW ADDRESS			APT. NO.
CITY			STATE ZIP CODE
HOME OR CELL (DAYTIME) PHONE NUMBER ( ) -	WORK PHONE NUMBER ( ) -	AGENCY NAME (NOT DIVISION)	

**3) HCFSA REIMBURSEMENT REQUESTS**

**Please read "Instructions and Important Information" on the reverse side before completing this form and refer to your enrollment information for HCFSA rules and regulations. If the service was provided for more than one day, show the beginning date and the ending date of the service. Each claim must be separated by patient, date/type of service and dollar amount.**

<b>1</b>	PATIENT LAST NAME	PATIENT FIRST NAME	MI.
DATE(S) OF SERVICE (MM/DD/YY) FROM ___/___/___ TO ___/___/___		TYPES OF SERVICE <input type="checkbox"/> Medical <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Hearing Aid	REIMBURSEMENT AMOUNT REQUESTED \$
CLAIM PERIOD (CHECK ONLY ONE) <input type="checkbox"/> 2020 Plan Year (services incurred 1/1/20 - 12/31/20) <input type="checkbox"/> 2019 Plan Year (services incurred 1/1/19 - 12/31/19) <input type="checkbox"/> 2019 Grace Period (services incurred 1/1/20 - 3/15/20 using 2019 balance)			
PROVIDER'S NAME			
PROVIDER'S ADDRESS - NUMBER AND STREET			APT. NO.
CITY			STATE ZIP CODE

<b>2</b>	PATIENT LAST NAME	PATIENT FIRST NAME	MI.
DATE(S) OF SERVICE (MM/DD/YY) FROM ___/___/___ TO ___/___/___		TYPES OF SERVICE <input type="checkbox"/> Medical <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Hearing Aid	REIMBURSEMENT AMOUNT REQUESTED \$
CLAIM PERIOD (CHECK ONLY ONE) <input type="checkbox"/> 2020 Plan Year (services incurred 1/1/20 - 12/31/20) <input type="checkbox"/> 2019 Plan Year (services incurred 1/1/19 - 12/31/19) <input type="checkbox"/> 2019 Grace Period (services incurred 1/1/20 - 3/15/20 using 2019 balance)			
PROVIDER'S NAME			
PROVIDER'S ADDRESS - NUMBER AND STREET			APT. NO.
CITY			STATE ZIP CODE

<b>3</b>	PATIENT LAST NAME	PATIENT FIRST NAME	MI.
DATE(S) OF SERVICE (MM/DD/YY) FROM ___/___/___ TO ___/___/___		TYPES OF SERVICE <input type="checkbox"/> Medical <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Hearing Aid	REIMBURSEMENT AMOUNT REQUESTED \$
CLAIM PERIOD (CHECK ONLY ONE) <input type="checkbox"/> 2020 Plan Year (services incurred 1/1/20 - 12/31/20) <input type="checkbox"/> 2019 Plan Year (services incurred 1/1/19 - 12/31/19) <input type="checkbox"/> 2019 Grace Period (services incurred 1/1/20 - 3/15/20 using 2019 balance)			
PROVIDER'S NAME			
PROVIDER'S ADDRESS - NUMBER AND STREET			APT. NO.
CITY			STATE ZIP CODE

**TOTAL REIMBURSEMENT AMOUNT REQUESTED (1+2+3) \$ \_\_\_\_\_**

**4) EMPLOYEE (PARTICIPANT SIGNATURE)**

The above is a true and accurate statement of unreimbursed health care expenses incurred by me and/or my eligible dependent(s) on the date(s) indicated. I certify that I and/or my eligible dependent(s) have incurred these expenses and have not been previously reimbursed and are not eligible for reimbursement through any other plan. I understand that expenses reimbursed herein cannot be deducted from my or anyone else's individual Federal Income Tax return. All claims submitted by me comply with the rules and definitions as set forth on the reverse side of this form. I understand that the Internal Revenue Code and the HCFSA Plan Document are the final authority in determining eligible expenses.

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

- Did you remember to:**
- Complete all sections?
  - Choose the correct claim period?
  - Sign and date the form?
  - Attach EOB statement(s), bill(s) and appropriate documentation?





## HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) PROGRAM CLAIMS FORM

Bowling Green Station, P.O. Box 707, New York, NY 10274  
Tel: (212) 306-7760 nyc.gov/fsa



### 1) INSTRUCTIONS AND IMPORTANT INFORMATION

1. A "Plan Year" is the calendar year (January 1-December 31) or for a newly eligible employee, any remaining portion thereof.  
A "Grace Period" is from January 1 through March 15 following the end of the current Plan Year. The HCFSA claim may be incurred during this period and reimbursed using the remaining balance from the participant's previous Plan Year's account.  
A "Claims Run-Out Period" is from January 1 through May 31 following the end of the current Plan Year, during which you may submit any outstanding or pending claims incurred during the Plan Year or the Grace Period. Claims received after May 31 will **not** be processed.
2. When submitting a claim either during the Grace Period or the current Plan Year, you should check the applicable box when completing your claim information. Please note that once a new Plan Year has begun, you may claim reimbursement with either the remaining balance in your previous Plan Year's account, or the new balance from the current Plan Year's account. Your reimbursement may also be divided between these two accounts.
3. **After the Claims Run-Out Period has ended, any unclaimed year-end balance in your account will not be carried into the next Plan Year and will be forfeited.**
4. Reimbursement can only be made for expenses resulting from services that have been received in the applicable Plan Year. No reimbursement can be made prior to services being received.
5. The minimum reimbursement amount requested must total \$50.00, unless your current account balance is less than \$50.00.
6. Only claims received by the close of the month will be processed for that month. Once your claims are approved, you will receive reimbursement at the end of the following month.
7. Attach the Explanation of Benefits (EOB) statement from your health insurance carrier(s) for medical expenses (i.e., deductibles, co-payments) and the EOB from your Welfare Fund for dental, vision and/or hearing expenses. Also, attach an itemized bill or receipt from your provider(s) for all eligible expenses. The date(s) of service on the claims form must match the date(s) of service on the EOB and the receipt or billing statement.

#### Each EOB, bill, receipt or claims form must contain the following information:

- Name of patient receiving service
- Type of service
- Date(s) of service
- Amount charged for service
- Name of provider rendering service

The HCFSA Program reserves the right to request additional documentation.

8. Attach a doctor's prescription and an itemized bill or receipt for over-the-counter (OTC) drug claims, or a copy of the product box containing the name of the OTC drug, if an itemized receipt is not available. You must attach a prescription receipt for prescription drug claims.

#### 9. Definitions:

- a) **Eligible Medical Expense:** An expense which has been incurred by the participant for qualifying health care expenses provided for an eligible health care recipient on or after the benefit effective date and which is eligible for reimbursement pursuant to the terms of the HCFSA Program
- b) **Qualifying Health Care Expense:** An expense incurred for an eligible medical service which is: (i) performed in regard to an eligible health care recipient; (ii) not reimbursable by a health insurance carrier and/or Welfare Fund; and (iii) not for the payment of health insurance premiums

**Note:** Any expense defined by the IRS as a non-deductible expense for income tax purposes shall be ineligible for reimbursement under HCFSA. Furthermore, an expense deductible for income tax purposes does not necessarily mean that it qualifies for reimbursement under this Program.

- c) **Eligible Health Care Recipients:** (i) the participant, who is eligible to be covered under the City of New York Employee Health Benefits Program (EHBP); (ii) the participant's spouse, who is eligible to be covered under the City of New York EHBP; and (iii) the participant's children who are eligible for coverage under the City of New York EHBP, including the participant's adult children who do not attain age 27 by the end of the Plan Year.

**Note:** Domestic partners/civil unions are not eligible health care recipients under HCFSA.

10. Be sure to sign and date this form. Return your completed form and proper documentation to the address shown above. You may obtain additional claims forms on the FSA website at nyc.gov/fsa.



The Health Care Flexible Spending Account Program is a division of the  
Office of Labor Relations' Flexible Spending Accounts Program  
**Health Care Flexible Spending Account (HCFSA) Program**  
**Medical Necessity Form**  
Bowling Green Station, P.O. Box 707, New York, NY 10274  
Tel: (212) 306-7760 nyc.gov/fsa

**Instructions:**

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement under the HCFSA Program when your health care provider certifies that they are medically necessary. In these cases, your provider must indicate your (or your spouse's or dependent's) specific diagnosis, specific treatment recommended, the length of treatment, and how this treatment will alleviate your medical condition. Please note that medical care must be for expenses to diagnose, cure, mitigate, treat or prevent disease or to affect any structure or function of the body.

Please give this form to your health care provider so that he or she may provide the required information in order to process your claim. Your provider may also submit a statement on his or her letterhead that includes all the information requested below.

By submitting this form, you certify that the expense you are claiming is a direct result of the medical condition described below, and you would not incur the expense you are claiming if you were not treating this medical condition.

You only need to submit this form, or a letter from your health care provider, with the first claim you submit for the service or product. However, if treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new form each year; they cannot be approved indefinitely.

**NOTE: Submitting this form does not guarantee that the expense will be reimbursed. You must also submit all claims to your health insurance carrier(s) before HCFSA can process your claims.**

If you have any questions, please contact the HCFSA Program at (212) 306-7760.

**PLAN YEAR:**

**EMPLOYEE/PATIENT INFORMATION**

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	MI	SOCIAL SECURITY NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PATIENT LAST NAME	PATIENT FIRST NAME	MI	RELATIONSHIP TO EMPLOYEE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
EMPLOYEE SIGNATURE			DATE
<input type="text"/>			<input type="text"/>

**TO BE COMPLETED BY PROVIDER**  I have attached a separate sheet with additional information.

PROVIDER NAME

PROVIDER ADDRESS

CITY  STATE  ZIP + FOUR  +

PROVIDER LICENSE NUMBER  PROVIDER TELEPHONE NUMBER (AREA CODE)  -  -  PROVIDER TELEPHONE NUMBER (AREA CODE)  -  -

DIAGNOSIS  CPT CODE

**RECOMMENDED TREATMENT****DESCRIBE HOW THE TREATMENT WILL ALLEVIATE THE MEDICAL DIAGNOSIS****LENGTH OF TIME TREATMENT REQUIRED**

PROVIDER SIGNATURE  DATE:

**OFFICE USE ONLY (DO NOT WRITE IN THIS BOX)**

REVIEW DATE	<input type="checkbox"/> ACCEPTED	REASON FOR DECLINE
<input type="text"/>	<input type="checkbox"/> DECLINED	<input type="text"/>
REVIEWED BY		<input type="text"/>
<input type="text"/>		<input type="text"/>



**Health Care Flexible Spending Account (HCFSA) Program  
Health Insurance Portability and Accountability Act (HIPAA)  
Protected Health Information (PHI) Authorization Form**

Bowling Green Station, P.O. Box 707, New York, NY 10274  
Tel: (212) 306-7760 nyc.gov/fsa

**PLEASE READ:**

We are unable to speak to anyone other than the participant about personal information or claims unless we have an authorization on file. If you would like to authorize a person to receive private information, please fill out this form. In order for the authorization to be valid, you must sign and fill out the form completely. You must list the specific person(s) or organization(s) you are authorizing in Section II. Also, you must provide a description of the information in Section III. For example, if you would like your spouse/domestic partner to receive information about your medical claims, you must list your spouse/domestic partner in Section II, and write "medical claims information" in Section III. Please return your authorization form to the address above, in care of "HCFSA HIPAA OFFICE."

**I. Participant Information**

LAST NAME		FIRST NAME		MI	SOCIAL SECURITY NUMBER	
					-	-
HOME ADDRESS NUMBER AND STREET						APT. #
CITY						STATE
						ZIP CODE
DATE OF BIRTH	HOME PHONE NUMBER (AREA CODE)	WORK PHONE NUMBER (AREA CODE)	MOBILE PHONE NUMBER (AREA CODE)			
/ /	( ) -	( ) -	( ) -	( ) -	( ) -	( ) -
AGENCY NAME						

**II. Specific person/organization (or class of persons) authorized to receive and use PHI:**

	LAST NAME	FIRST NAME	RELATION TO PARTICIPANT
1.			
2.			
3.			
4.			
5.			
6.			

**III. Specific description of the information (medical examination reports, Explanation of Benefits, etc.) and the purpose for which it may be used or disclosed (to assist in resolving a claim, at the participant's request, etc.)**

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**IV. Acknowledgement and Right to Revoke:**

I authorize the HCFSA Program to use or disclose my individually identifiable health information as outlined above. I understand that I can refuse to sign this authorization and that I can inspect or copy the health information that is used or disclosed in accordance with this authorization. I understand that I have the right to revoke this authorization at any time by notifying the HCFSA Program in writing at Bowling Green Station, P.O. Box 707, New York, NY 10274 . I understand that the revocation is only effective after it is received and logged into the HCFSA database. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my employment with the City terminates.

SIGNATURE	DATE
	/ /

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

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