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FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Please Complete When Faxing	Date: _____
	# of Pages: _____
	Return Fax #: _____

CLAIM INFORMATION

Total Amount of Reimbursement Requested $ _____

Participant Signature: _____ **Date:** _____

I certify that all expenses listed on this request have not been reimbursed by any other source, nor will they be reimbursed by any other source. Additionally, I certify that I have read the reverse side of this claim form (page 2) and the expenses listed meet all of the IRS guidelines.

PARTICIPANT INFORMATION

SSN (optional): _____ **Employer:** _____

Employee Name: _____ (First Name) _____ (Middle Initial) _____ (Last Name)

E-mail Address: _____

Current Address: _____ (Street Address) _____ (Floor or Apt No.)

☐ Check if Change of Address

_____ (City, State Zip)

Phone Number: _____ (Cell Phone Number) _____ (Home Phone Number)

Helpful Hints to Expedite Your Reimbursement

Please follow these simple guidelines when submitting your claims for reimbursement:

- Please list one patient and service per line. The type of service field indicates what type of service was provided. For example,
- HC = Health Care, DC = Dependent Care, PK = Parking, TR = Transit, BC = Bicycle (if parking, transit, or bicycle commuter is offered by your employer).
- In accordance with IRS regulations, the actual date which services were rendered is required. Many providers and insurance bills have a separate billing date. Please do not mistake the billing date for the date services were performed.
- **Fax tips:** Please print information using black ink to ensure readable transmission. **If the documents are faint, highlighted or distorted, they will not transmit clearly and may not be readable when we receive them. If the transmitted documents are not readable, a letter will be sent requesting legible documentation.**

Reimbursement Guidelines

In order to receive reimbursement, supporting documentation must be attached to this completed claim form (including expense itemization). Please include an itemized statement from the provider listing dates of service, service performed, charge and the name of the patient receiving the service. **If you have insurance,** please submit the corresponding **Explanation of Benefits (EOB)** from your insurance company that details their payment and the amount for which you are responsible. If this claim form is incomplete a letter will be sent to you requesting completion before processing.

Date Services Were Provided	Patient Name	Name of Provider Service	Type of Service (circle only one)	Net Amount
			HC DC	$
			HC DC	$
			HC DC	$
			HC DC	$
			HC DC	$
			HC DC	$
			HC DC	$
			HC DC	$

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Flexible Spending Account Reimbursement Request Certification

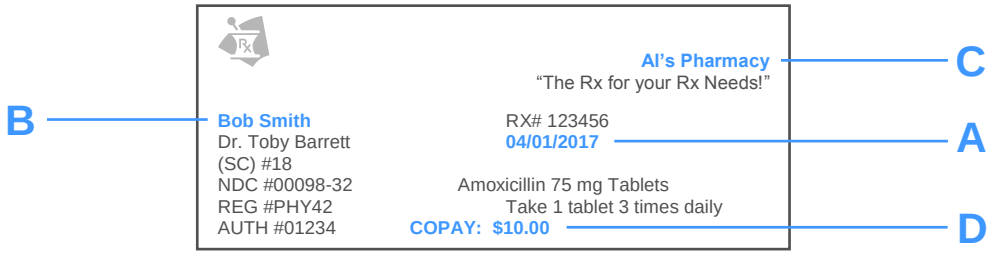
I certify that I am claiming reimbursement only for eligible expenses incurred by qualifying individuals while a participant under the plan and during the applicable year. These expenses have not, nor will be, reimbursed from any other source and have not and will not be claimed as an income tax deduction. The attached documentation and/or Explanation of Benefits (EOB) support all expenses for which I am claiming reimbursement. ***Note: "incurred" as used throughout this reimbursement form refers to the date(s) that the participant is provided with the medical care that gives rise to the medical expenses and not to the dates when the participant is formally billed, charged or pays for the medical care.**

Helpful Claims Information and General Submission Tips

- IRS guidelines require the submission of third party documentation which includes **1) DATE OF SERVICE, 2) DESCRIPTION OF SERVICE**, including both procedures performed and the condition treated and **3) TOTAL COST OF SERVICES**. Acceptable documentation generally includes an Explanation of Benefits (EOB) from your medical insurance carrier and/or a receipt from your provider detailing **DATE OF SERVICE, DESCRIPTION OF SERVICE and COST OF SERVICES**. The following types of documentation will not be accepted: **CANCELLED CHECKS, CREDIT CARD RECEIPTS OR STATEMENTS, BALANCE FORWARD STATEMENTS**.
- Ineligible Expenses: This is a partial list of health care expenses that are not eligible for reimbursement from your Health Care Reimbursement Account:
  - Cosmetic surgery or procedures of any kind
  - Solutions for the care and maintenance of eyeglasses
  - Health club memberships
  - Union dues or insurance premiums
  - Physical or massage therapy treatments of general well-being
  - Domestic Help fees (non-medical nature)
  - Lens replacement insurance
  - Herbs and supplements (Including vitamins and Glucosamine)
- All claims must be made on a signed, fully completed and itemized claim form. **Please note that upon receipt of an unsigned or incomplete claim form, a letter will be sent requesting that the participant sign or complete the form before processing.**
- **Pharmacy/Prescription Charges:** Documentation is required from the pharmacy that includes the patient's name, name of pharmacy, date of service, prescription number, name of drug, NDC number, and cost of the prescription. Please be aware that weight loss and cosmetic medication are typically not covered.
- **TIMELY SUBMISSION OF CLAIMS:** All claims incurred during the plan year, or while you were a participant in the plan, must be submitted by the end of your employer's designated grace period as contained in your Company's Summary Plan Description. Should you wait until the end of this grace period to submit your claims, you run the risk of forfeiture of any unused amounts in your account should your claim not include all the necessary documentation required. **Any new claims or documentation submitted after the grace period cannot be considered for reimbursement.**
- **A claim is not reimbursable until the total amount of the reimbursement meets or exceeds $25.00.**
- **Documentation for Dependent Care Reimbursement must include :**
  - Name of person(s) being cared for
  - Date for service coverage
  - Federal Tax ID or SSN for the person providing care
  - Charge for the service

EXAMPLE

Date Services Were Provided	Patient Name	Name of Provider Service	Type of Service (circle only one)				Net Amount
A	B	C	HC	DC	PK	TR	D



Reimbursement Tips: The above example details the required information contained on a typical provider receipt. The DATE OF SERVICE in this instance is the day that the prescription was filled. On the other types of documentation, the DATE OF SERVICE may not be as clear or there may be more than one date. In that case, use the date that SERVICES WERE ACTUALLY RENDERED, NOT THE PAYMENT DATE. You may also notice that the SERVICE PROVIDER is "Al's Pharmacy" and not the doctor that prescribed the medication. The SERVICE PROVIDER is the company or party that charged for the service – the doctor, Walgreen's, Pearle Vision, etc. Services for Chiropractic, Acupuncture, Message, Medical/Orthopedic Supplies or LASIK are Health Care related Services (HC). When submitting an orthodontia claim, please make sure that you have submitted the treatment contract from your provider before submitting claims for monthly payments and other miscellaneous orthodontia supplies such as retainers, repairs, X-rays or examinations.