# FSA/HRA REIMBURSEMENT CLAIM FORM (Please Print Clearly)

PART 1	PART 2 Check here if address has changed and provide new information below.			
Employee Name:	Street or PO Box:			
Member ID:	City:			
Employer:	State:		Zip Code:	
PART 3				
Provider & Service Rendered/Item Purchased	*Pay from Prior PY?	Date(s) of Service	Amount	For Office Use Only
	T YES			
	☐ YES			
	☐ YES			
	T YES			
TOTAL →				

Submit claim by:

Sign Here

# Signature Required:

Date:

Fax: (585) 427-9320 or

Mail: ATTN: Claims Department **Benefit Resource, Inc.** 245 Kenneth Drive Rochester NY 14623-4277



Employee Certification: By signing the above, I request reimbursement for Medical and/or Dependent Care expenses listed above. Enclosed are itemized bills, receipts or EOBs verifying these expenses. Each expense listed is for a service/item provided to me, my spouse or an eligible dependent, has not been purchased with a Beniversal® MasterCard® Prepaid Card, and will not be reimbursed from any other source. Medical expenses were incurred only for an immediate medical purpose. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and cannot be claimed as deductions on my personal income tax.

\*If your plan offers the extended grace period allowed by IRS regulations, you must check Yes if you wish to have this expense reimbursed from the prior plan year.

### **INSTRUCTIONS FOR SUBMITTING YOUR CLAIM:**

- 1. Part 1 of the claim form *must* be completed in full.
- 2. Part 2 of the claim form should only be completed if your address has changed.
- 3. Part 3 of the claim form *must* be completed in full.
- 4. For each item you are claiming in Part 3, you must attach a copy of itemized bills, statements, receipts or insurance company Explanation of Benefits (EOBs). This documentation from your provider must include the following information (please retain originals for your personal records).
  - Name of provider
  - · Your out-of-pocket cost for the service • Date(s) service was provided · Name of person receiving the service
  - Type of service provided (for prescriptions, must include name of drug)
- 5. IRS regulations require additional documentation for the following:
- Effective 01/01/2011, over-the-counter drugs and medicines require a prescription.
- Dual purpose items require a Certification of Medical Necessity form (can be obtained from the Benefit Resource website).
- 6. The claim form *must* be signed and dated after reading the Employee Certification.
- 7. Submit the completed claim form and all related documentation to: Fax: (585) 427-9320 or ATTN: Claims Department
  - Benefit Resource, Inc. 245 Kenneth Drive

#### **CLAIM SUBMISSION REMINDERS:**

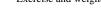
- Credit card statements, cancelled checks and balance forward/prior balance statements are not acceptable.
  - The service being claimed must be provided to you, your spouse or your eligible dependent within the time frame indicated in your Plan Highlights.
- In general, IRS regulations do not require that you pay for a service before requesting reimbursement. A request for reimbursement must be based on the date when the service was provided, not the date when a payment was made. (The IRS allows one exception: orthodontia expenses can be based on date of payment, date of service or payment due date on statements/coupons.)
- Claims must be submitted after a service is provided, but before the end of the run-out period following the end of your plan year.
- Claims must be received by Benefit Resource. Inc. within the time frames specified in the Plan Highlights.
- An expense paid with the Beniversal Card or that has been reimbursed from any other source cannot be submitted for reimbursement.
- Items on a claim form or supporting documentation should never be highlighted since highlighted items can be hard to read.

# SOME EXPENSES THAT ARE Not ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT INCLUDE:

- Personal care items (e.g. shampoo, soap, electric toothbrush, toothpaste, mouthwash)
- Teeth whitening
- Insurance premiums

### SOME EXPENSES ARE ONLY ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT IF CERTIFIED BY A LICENSED MEDICAL PROVIDER AS PREVENTING, TREATING, OR MITIGATING A SPECIFIC PHYSICAL DEFECT OR ILLNESS:

- Cosmetic services Vitamins
- Non-prescription sunglasses · Exercise and weight loss programs





Phone: (800) 473-9595 Website: www.BenefitResource.com

Rochester NY 14623-4277