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*
	☐ YES			
	☐ YES			
	☐ YES			
	☐ YES			
	☐ YES			
	☐ YES			
	☐ YES			
	☐ YES			
	☐ YES			
	TOTAL ➜		$0.00	

Submit claim by:

Fax: (585) 427-9320

or

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

Benefit Resource, Inc.
plans that perform

Sign Here

Signature Required: _____ ***Date:*** _____

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
   - Date(s) service was provided
   - Type of service provided (for prescriptions, must include name of drug)
   - Your out-of-pocket cost for the service
   - Name of person receiving the service
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
   Rochester NY 14623-4277

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

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