Benefit Advantage
PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

 # Pages:_____

Company Name:_____

Health Care FSA CLAIM FORM

NAME:	Last		First		MI	**SS#**	
ADDRESS:	Street	City		State	ZIP	**PHONE:**	( )

☐ **Please check if this is a new address**

MUST FILL OUT — **MEDICAL EXPENSE CLAIMS**

Patient Name	Relationship	Date of Service MM/DD/YY	Name of Provider	Claim Amount	Description of Service
SAMPLE John Doe	SAMPLE Spouse	SAMPLE 01/01/03	SAMPLE Prevea Clinic	SAMPLE $10.00	SAMPLE Office Visit
			Total:		

There is a $25 minimum payment amount.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

You must attach documentation that includes the following information for your claim to be paid:

- Date(s) of Service Performed
- Description of Service Performed *(i.e. eye exam, co-pay)
- Amount of expense incurred
- Name of Patient, & Service Provider

*Undefined codes are not acceptable descriptions of your expense.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal.Revenue Service regulates this Flexible Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:**____/____/____

Original receipts will not be returned, please keep a copy for your own records.

You may review your account at www.benefitadvantage.com for balance details.

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HOW TO FILE YOUR REQUEST

DEFINITION OF MEDICAL CARE:

Must be "for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body". Special rules may apply.

STEP I

Complete ALL personal information on the reimbursement request form. All items you are requesting reimbursement for should be itemized. Failure to complete your claim form could result in a delay or denial of your claim.

STEP II

HEALTH CARE FLEXIBLE SPENDING ACCOUNT:

Cancelled checks, balance due statements, cash register receipts or credit card statements are not acceptable per IRS Regulations. The only exception is that cash register receipts are allowed for contact lens supplies, eligible over the counter expenses and diabetic supplies. Photocopies and faxes of documents are acceptable. We will not return original receipts.

Attach proper documentation to the claim form:

- The insurance explanation of benefits (EOB) indicating the amount for which you are responsible (including deductibles). Any medical, dental, or vision expense covered by insurance (in part or in full) must first be submitted to your insurance carrier.

OR

- An itemized bill with the following (if you have no insurance coverage for your health care expense).

  - Name of provider and patient
  - Service cost, date, and description
  - Notation when there is NO insurance coverage

OR

- Co-pay receipts if you are covered under an HMO or a prescription drug plan.

If you have more claims than the spaces provided please attach additional claim forms.

STEP III

SIGN the request form.

The Internal Revenue Service regulates this Flexible Spending Account. Our documentation guidelines are intended as a means to qualify your expenses for approval and reimbursement. It is the responsibility of each participant to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements will delay the payment of your claim.

Our goal is to process payments within 24 hours of receipt with proper documentation. We guarantee a 5 working day turnaround maximum. There is a $20 stop payment fee for all checks that need to be reissued. Direct Deposit is available at no charge and is highly recommended.

This outline is intended for quick reference. If you have any additional questions, please call the Flexible Spending Account Department at (920) 339-0351 or (800) 686-6829, available 8-4:30pm, Monday through Thursday and 8-4 pm on Friday Central Standard Time.