Submitting Your Healthcare Flexible Spending Account Reimbursement Request Form

Receiving reimbursement is easy!

1. Complete a Flexible Spending Account Reimbursement Request form.
2. Attach itemized and complete documentation and, if required, your physician’s statement of medical necessity.
3. Please attach one receipt per “documentation page.”
4. Fax the form and supporting documentation to Benesyst.

What are the options for submitting my claim?

Online: www.benesyst.net  
Fax: (800) 310-8279  
Mail: Benesyst Claims  
800 Washington Avenue N. 8th Floor  
Minneapolis, MN 55401

Our online claims wizard is the easiest way to claim! How?

- Click View My Personal Flexible Spending Account Information.
- Scroll down and click on the Healthcare FSA Online Claims Wizard.
- Follow the easy instructions! You can upload or fax the resulting form and your documentation.

Helpful tips for faxing your claim:

1. Do not use a highlighter on receipts to be faxed.
2. Always keep a complete copy of your entire claim.
3. Attach one receipt per “documentation page.”
4. Use a separate page for additional receipts.
5. Be sure to sign and date your claim form.

Tip: Please pay attention to the order in which you fax your form and documentation. First, fax the FSA Reimbursement Request form, followed by your supporting documentation. No need to fax the instructional pages. Also, check your fax machine for special sending or receiving instructions.

Make sure to place your claim face up or face down, depending on your fax machine’s requirements. If the form is transmitted upside-down, the fax will be received as a blank page and this will prevent processing or acknowledgement of your claim.

Why is providing documentation important?

The IRS strictly requires that expenses reimbursed through an FSA be accompanied by complete documentation showing the participants responsibility for payment to the provider. Claims submitted without correct documentation cannot be approved, will be declined for improper documentation, and you will receive a denial letter from Benesyst. We need a date of service or purchase to prove that it was incurred during the plan year, regardless of the date you paid for it. We will also need a description of service to prove that the expense is eligible.

Expenses covered by insurance are best documented with a copy of the Explanation of Benefits (EOB) from the plan or carrier and reimbursement is limited to the patient responsibility amount.

Cancelled checks, credit card receipts, balance forward, and financial account statements cannot be used to document a claim. Previously denied claims must be completely resubmitted for processing.
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It’s the tax break you can’t afford to ignore—review the instructions to submit your claim!

Please print or type entries in all caps. Include your Social Security Number, name, daytime phone, name of employer.

Be sure to sign and date your claim form.

Fill in the cost of each item.

Fill in the sum total of all line items on the claim form.

Example of an acceptable and an insufficient receipt for processing your claim:

**Required Information**

- Provider name and contact information: XYZ Medical Associates
  1234 Medical Street
  Anywhere, WY 11111
  999-555-5555
- Date expense incurred: 01-01-2009
- Time: 08:08PM
- Plan Member: John Doe
- ACCT: XXXXXXXX1111
- AUTH: 1111
- TOTAL DUE: $25.00
- AMOXICILLIN 500 MG
  Quantity 28
- National Drug Code: 00000-0000-00
- Refills Remaining 1 Refillable until 01/01/2010

**Insufficient Information**

- No description of items purchased

**Expense Types**

- Co-payment, co-insurance, EOB and deductibles - label as “Health”
- Prescription—label as “R”
- Orthodontia—label as “Dental”
- Eye exams, glasses, and contacts—label as “Vision”
- Purchases of over the counter items should be labeled as “OTC” - Please note that OTC drugs or medicines, in general, are no longer eligible for reimbursement effective 1/1/2011 due to healthcare reform. Please see the Benesyst website for more information.

**Helpful Hints**

- Be sure to completely fill in the circle for the type of expense incurred and whether any portion of the expense will be covered by insurance.
- The date the expense was incurred should match the date on your receipt or EOB. List the name of the physician or merchant from which the expense was incurred.
- Confirm all fields are complete and correct, then submit your claim form and supporting documentation.

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### Account Holder Information

(If in ALL CAPITAL letters) (i.e. A B C D E)

<table>
<thead>
<tr>
<th>Participant’s Daytime Phone (with Area Code first)</th>
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<tbody>
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<td></td>
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<table>
<thead>
<tr>
<th>Participant’s First Name</th>
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<table>
<thead>
<tr>
<th>Participant’s Last Name</th>
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<table>
<thead>
<tr>
<th>Participant’s Employer Name</th>
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<thead>
<tr>
<th>Participant’s Email Address</th>
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### Participant Statement and Signature

**PLEASE READ CAREFULLY:**

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred/rendered during a period while I was covered under the Company’s Flexible Spending Account Plan with respect to such expenses and that the health care expenses are for medical care and, if applicable, have not been reimbursed or are not reimbursable under any other health plan coverage. I, the undersigned, certify that those expenses were incurred by me, or a federally eligible dependent, and are expenses permitted under federal law. I fully understand that I alone am responsible for the sufficiency, accuracy and completeness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

**X**

### Expense Information

<table>
<thead>
<tr>
<th>Start Date of Service</th>
<th>Amount</th>
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<tbody>
<tr>
<td>(Month-Day-Year)</td>
<td>(i.e. 01-23-09)</td>
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</table>

<table>
<thead>
<tr>
<th>Service Type:</th>
<th>Health □</th>
<th>RX □</th>
<th>Dental □</th>
<th>Vision □</th>
<th>OTC □</th>
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<tbody>
<tr>
<td>Insured for:</td>
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<td>Child □</td>
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**Please Fax Your Claim To** (800) 310-8279

**Or Mail to:** Benesyst Claims, 800 Washington Ave. N. 8th floor, Minneapolis, MN 55401

**Total Expenses**
Documentation Page
Place Reimbursement Form on Top and Fax to (800) 310-8279.

Please tape smaller items in the center of this page. Use a new page for each item. If your item is the size of this page, please fax as an individual page.