

# Submitting Your Healthcare Flexible Spending Account Reimbursement Request Form

It's the tax break you can't afford to ignore—review the instructions to submit your claim!

## 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](http://www.benesyst.net)

Fax: (800) 310-8279

Mail: Benesyst Claims  
800 Washington Avenue N. 8<sup>th</sup> Floor  
Minneapolis, MN 55401

## Benesyst Healthcare FSA Online Claims Wizard is the easiest way to claim! How?

- Log in to [www.benesyst.net](http://www.benesyst.net).
- 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. 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 include the instructional pages or a cover sheet.

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.

Turn around time for a Healthcare Reimbursement is **five** business days.

**Please note:** Over-the-counter (OTC) items must be clearly listed on the receipt. Abbreviations or non-descriptive listings will not be accepted. If the detail on the receipt is unclear, please include a copy of the product packaging; handwritten clarification cannot be used to supplement the receipt details.

## 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 will not be approved, and you will receive a denial letter from Benesyst. Regulations require a date of service/purchase to prove when the expense was incurred, regardless of the date you paid for it. Regulations also require 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. Partial documentation to support a previously denied claim cannot be accepted for processing. Please resubmit your claim in full.

# Submitting Your Healthcare Flexible Spending Account Reimbursement Request Form

It's the tax break you can't afford to ignore—review the instructions to submit your claim!

**Flexible Spending Account  
Health Care Reimbursement Request Form**

**Account Holder Information**  
(Please print in ALL CAPITAL letters) (Use A B C D E)  
Participant's Social Security Number (Values to provide per 100 may vary greatly)  
Participant's Daytime Phone (with Area Code first)  
Participant's First Name  
Participant's Last Name  
Participant's Employer Name  
Participant's Email Address \*Automatic Opt in to receive information via email from Benesyst. Your address is not shared.  
Participant's Signature  
Participant's Date

**Expense Information**

Start Date of Service (Month/Day/Year)	Name of Provider	Service Type	Amount
01-01-09	ABC MEDICAL	Health <input checked="" type="radio"/> RX <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> OTC <input type="radio"/>	99.00
		Spouse <input type="radio"/> Child <input type="radio"/> Covered by Insurance: Yes <input type="radio"/> No <input checked="" type="radio"/>	
		Insured for: Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Covered by Insurance: Yes <input type="radio"/> No <input type="radio"/>	
		Health <input type="radio"/> RX <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> OTC <input type="radio"/>	
		Spouse <input type="radio"/> Child <input type="radio"/> Covered by Insurance: Yes <input type="radio"/> No <input type="radio"/>	
		Health <input type="radio"/> RX <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> OTC <input type="radio"/>	
		Spouse <input type="radio"/> Child <input type="radio"/> Covered by Insurance: Yes <input type="radio"/> No <input type="radio"/>	
		Health <input type="radio"/> RX <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> OTC <input type="radio"/>	
		Spouse <input type="radio"/> Child <input type="radio"/> Covered by Insurance: Yes <input type="radio"/> No <input type="radio"/>	
Total Expenses			99.00

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.

## Expense Types

- Co-payment, co-insurance, EOB and deductibles—label as “Healthcare.”
- Prescription—label as “RX”
- Orthodontia—label as “Dental.”
- Eye exams, glasses, and contacts—label as “Vision.”
- Purchases of over the counter items should be labeled as “OTC.”

## 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 to Benesyst.

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

	Required Information	Insufficient Information
Provider name and contact information	XYZ Medical Associates 1234 Medical Street Anywhere, WY 11111 999-555-5555	XYZ Medical Associates 1234 Medical Street Anywhere, WY 11111 999-555-5555
Date expense incurred	Date: 01-01-2009      Time: 08:08PM Plan Member: John Doe ACCT: XXXXXXXXXX1111 AUTH: 1111	Date: 01-01-2009      Time: 08:08PM Plan Member: John Doe ACCT: XXXXXXXXXX1111 AUTH: 1111
Description of the expense	TOTAL DUE: \$ 25.00 AMOXICILLIN 500 MG Quantity 28 National Drug Code: 00000-0000-00 Refills Remaining 1 Refillable until 01/01/2010	TOTAL DUE: \$ 25.00 Sign to accept the above amount X _____

No description of items purchased

# Flexible Spending Account Health Care Easy Reimbursement Request Form



## Account Holder Information

(Please print in ALL CAPITAL letters) (i.e. ABCDE)

Participant's Daytime Phone (with Area Code first)

\_\_\_\_-\_\_\_\_-\_\_\_\_

Participant's Social Security Number \*Failure to provide your SSN may delay processing

\_\_\_\_-\_\_\_\_-\_\_\_\_

Participant's First Name

\_\_\_\_\_

Participant's Last Name

\_\_\_\_\_

Participant's Employer Name

\_\_\_\_\_

Participant's Email Address \*Automatic Opt in to receive information via email from Benesyst. Your address is kept 100% confidential.

\_\_\_\_\_

\*FSAHC01\*



## Participant's 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 these 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 truthfulness 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**

Participant's Signature

Date

## Expense Information

Start Date of Service (Month-Day-Year) (i.e. 01-23-09)	NOTE: Please report <u>only one</u> expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.	Amount (i.e. 24.99, do NOT include the \$)
____-____-____	Name of Provider _____ Service Type: Health <input type="radio"/> RX <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> OTC <input type="radio"/> Incurred for: Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Covered by Insurance: Yes <input type="radio"/> No <input type="radio"/>	____.____
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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. Please make copies of this page as needed.*

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