BENEFIT SOLUTIONS, INC.
Employee Benefits Administration

Reimbursement Claim Form

INSTRUCTIONS: ***FOR EXPENSES PAID WITH FSA/HRA DEBIT CARDS DO NOT COMPLETE THIS FORM!***

1. **Complete the entire claim form**.

FSA/HRA Debit Card charges only require you to submit your documentation. ***DO NOT*** *fill out this form for Debit Card claims.*

2. **Attach Medical Expense Valid Receipts:**
   You must have one of the following valid receipts to substantiate your claim:
   - Store/Pharmacy receipt, including name of product and date of service
   - Co-pay receipt from medical provider, including date of service
   - Itemized bill from medical provider, including date of service
   - Insurance company's "Explanation of Benefits", including date(s) of service – if allowed by insurance
   - ***Canceled checks and credit card statements are not valid receipts.***
     - Effective 1/1/2011, over-the-counter drugs and medicines require a prescription in addition to a valid receipt, to be reimbursed. Over-the-counter supplies and equipment remain eligible for reimbursement with a valid receipt. Your receipts must contain the name of the product to be reimbursed.
     - Documentation from a physician must accompany receipts if they are for medical expenses that seem as if they would not be accepted for reimbursement. For example, massage therapy or weight loss programs are not typically reimbursable, but could be if prescribed by a physician.
3. **Note the claim line number at the top of each attachment**. For example, note "L1" on your documentation for the health care expense listed first on the claim form. If one document is provided to support more than one claim line, note all applicable claim lines on the attachment.
4. **Read the Certification Statement then sign and date the claim form.**
5. Keep a copy of this form and all supporting documentation for your records.

Employer Name: _____

Employee Name: _____

Line #	Service Date(s) m/d/yy **to** m/d/yy	Service Provider	Type of Service (Medical, Dental/Ortho, Vision, Child Care, Parking)	Patient Name	Amount Requested
L1	/ / **to** / /				
L2	/ / **to** / /				
L3	/ / **to** / /				
L4	/ / **to** / /				
L5	/ / **to** / /				
L6	/ / **to** / /				
L7	/ / **to** / /				
L8	/ / **to** / /				
L9	/ / **to** / /				
L10	/ / **to** / /				
				Total Expenses Claimed	**$**

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 (joint) income tax return. Any person who knowingly and with intent to injure, defrauds 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. Where indicated, parking amounts claimed are without an available receipt and this certification includes such expenses.

Employee Signature: _____ **Date:** _____

Return Completed Claim form with Supporting Documentation to BSI via:

Mail: Benefit Solutions, Inc. Attn: FLEX, PO Box 6, Mukilteo, WA 98275

Fax: 1-866-727-2106 **E-Mail:** Flexspending@bsitpa.com

Customer Service Telephone Number: 206-859-2694