

# BENEFITHELP

## Solutions

### Healthcare Flexible Spending Account Claim Form Public Employees' Benefit Board Group #8743

(Please Print)

Employee Benefit Number:  
P followed by 8 numbers

Employee Name:

Home/Mailing Address:

CHECK HERE IF NEW

\_\_\_\_\_

\_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI)

\_\_\_\_\_ (Street)

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

**IMPORTANT** - Instructions for completing a claim form:

1. Complete the entire claim form, including signature and date. Failure to complete the form in its entirety (including the itemization of each expense) and attaching supporting documentation may cause a delay in processing your claim. If you require more space please attach a separate sheet that includes the same information as on the form.
2. Attach supporting documentation. Canceled checks, credit card receipts, statements, balance forward or balance due statements are not acceptable.
  - a. To submit **healthcare expenses**, attach supporting documentation that includes the date of service, name of the provider, service performed and the amount of the charge(s). An Explanation of Benefits (EOB) from your insurance company, an itemized billing statement, or a receipt from your provider is an acceptable form of documentation.
  - b. To submit **prescription expenses**, attach the prescription label or an itemized pharmacy ledger that include the date of service, pharmacy name, the prescription number and the cost of the prescription(s).
  - c. To submit **orthodontia expenses**, attach a copy of the orthodontia contract. The orthodontia contract must include the total charges, less insurance payments or down payments, date treatment began and the length of treatment. We may request additional information.
3. **Keep** a copy of the completed claim form and supporting documentation for your files.
4. **New Grace Period** allows you to submit claims from the new plan year and receive reimbursement from previous year left over funds. The Grace Period runs from January 1<sup>st</sup> – March 15<sup>th</sup>.
5. **All** claims must be submitted by March 31<sup>st</sup> including the Grace Period Claims for reimbursement.
6. For reassignment of claims processed in the grace period, please complete the Claim Reallocation form. For assistance contact BenefitHelp Solutions.

**Healthcare Expenses** – Use a separate line for each expense. Attach a separate sheet if needed. Attach supporting documentation as explained in 2.

Date of Service		Name of Provider	Name of Dependent/Self	Amount Requested	INTERNAL USE ONLY
From: mm/dd/yy	To: mm/dd/yy				
<b>TOTAL:</b>					

I request reimbursement from my Flexible Spending Account for the listed expenses paid by me. I certify these expenses are not covered by or reimbursable from any other source. I understand the limitations and qualifications and federal regulations of this program.

Participant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

R09/06