Flexible Spending Account (FSA) Reimbursement form

☐ **Check box if this claim is to offset a previously submitted ineligible expense.**

PLEASE PRINT CLEARLY

*** This information is mandatory.** Reimbursement may be delayed if fields with an asterisk are not filled out. Please do not use a fax cover sheet.

Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth ____ / ____ / ________	* SSN or BHS Identification number
* Mailing address		* City	* State	* ZIP
* Email address		* Contact phone number		☐ New address
* Employer				* Group identification number (if known)

Section 2 Reimbursement request

1	* Name of dependent or self		* Service start date (MM/DD/YY) ____ / ____ / ________	* Service start end (MM/DD/YY) ____ / ____ / ________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
2	* Name of dependent or self		* Service start date (MM/DD/YY) ____ / ____ / ________	* Service start end (MM/DD/YY) ____ / ____ / ________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
3	* Name of dependent or self		* Service start date (MM/DD/YY) ____ / ____ / ________	* Service start end (MM/DD/YY) ____ / ____ / ________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
If you need more space, please use page two. Each page will contain its own total.			* Total on this form	

Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. For a list of common eligible and ineligible expenses and additional information on substantiation please visit benefithelpsolutions.com/pdfs/fsa_expenses.pdf. An explanation of benefits provided by your insurance company is acceptable substantiation. You may need to submit a letter of medical necessity at benefithelpsolutions.com/pdfs/med_necessity_ltr.pdf to establish the medical necessity of your medical expenses. For orthodontia expenses, BenefitHelp Solutions must have a copy of your orthodontia contract on file.

Section 3 Authorization

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for eligible expenses incurred by myself, my spouse, or my dependent while I was a participant in the plan.
- These services have already been provided or paid for.
- I have not and will not seek reimbursement for this expense from any other plan or party.
- I understand BenefitHelp Solutions reserves the right to deny a claim if I have not provided substantiation or if there is reason to believe the expense is not qualified as defined under the conditions in my Summary Plan Document or regulatory guidance.

* Employee signature X	* Signature date

Ready to submit? Mail, fax, email, or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268

Fax: 888-249-5058 **Email:** Claims@benefithelpsolutions.com **Online:** benefithelpsolutions.com

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Account holder information

* First name	M.I.	* Last name	* Date of birth _____ /_____ / ___________	* SSN or BHS Identification number
* Mailing address	* City	* State	* ZIP	
* Email address	* Contact phone number	☐ New address		
* Employer	* Group identification number (if known)			

Reimbursement request

4	* Name of dependent or self		* Service start date (MM/DD/YY) _____ /_____ / ___________	* Service start end (MM/DD/YY) _____ /_____ / ___________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
5	* Name of dependent or self		* Service start date (MM/DD/YY) _____ /_____ / ___________	* Service start end (MM/DD/YY) _____ /_____ / ___________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
6	* Name of dependent or self		* Service start date (MM/DD/YY) _____ /_____ / ___________	* Service start end (MM/DD/YY) _____ /_____ / ___________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
7	* Name of dependent or self		* Service start date (MM/DD/YY) _____ /_____ / ___________	* Service start end (MM/DD/YY) _____ /_____ / ___________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
8	* Name of dependent or self		* Service start date (MM/DD/YY) _____ /_____ / ___________	* Service start end (MM/DD/YY) _____ /_____ / ___________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
9	* Name of dependent or self		* Service start date (MM/DD/YY) _____ /_____ / ___________	* Service start end (MM/DD/YY) _____ /_____ / ___________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
10	* Name of dependent or self		* Service start date (MM/DD/YY) _____ /_____ / ___________	* Service start end (MM/DD/YY) _____ /_____ / ___________
	* Name of provider or merchant	Product description		* Out-of-pocket cost
Each page will contain its own total.			* Total on this form	

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