Flexible spending account reimbursement form

BENEFITHelp Solutions

To help us process your reimbursement request quickly, please print clearly and return this form as instructed. Please complete all sections of this form. If this form is incomplete or requires additional information, your reimbursement may be delayed. Please do not use a fax cover sheet.

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

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Mailing address	* City	* State	* ZIP
* Contact number	* Email address		☐ New address
* Employer			* Group identification (if known)

Section 2 Reimbursement request

1	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (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 end date (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 end date (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 (please read and sign below)

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 my own personal expenses.
- 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	* Signature date
X	

** Reimbursement may be delayed if fields with an asterisk are not filled out.*

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

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com

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

Additional reimbursement requests

Account holder information

*First name	M.I.	*Last name	*Membership identification
*Employer			*Group identification (if known)

Reimbursement request

4	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (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 end date (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 end date (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 end date (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 end date (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 end date (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 end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
11	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
12	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (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

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.

** Reimbursement may be delayed if fields with an asterisk are not filled out.*