Flexible Spending Account Claim Form Instructions

(Do not fax or mail this instruction page)

Options: ***Please use option 1 for faster reimbursement***

1. Online: Log in to your account. Submit your claim online and attach the image or scanned copy of your receipt.

2. Fax or Mail: Enter the claim online, then print the online fax cover sheet and submit the cover sheet and receipt through Fax or Mail. Otherwise complete and sign this claim form attaching the copy of your receipt and submit through Fax or Mail.

Fax: **1.866.228.9417**

Mail: **Spending Account Processing**

PO Box 25173, Lehigh Valley, PA 18002-5173

-- Please make sure that you fax or mail the claim form and the related supporting documentation together. The claim form should be the first page in the stack of pages that you fax.

Instructions:

• Please print or write in capital letters, with the letters centered in the boxes

• Complete all information of " Your Information"- Section 1

• Use your documentation to complete "Your Expenses"- Section 2 of the form, including the following:

1. Doctor or service provider name

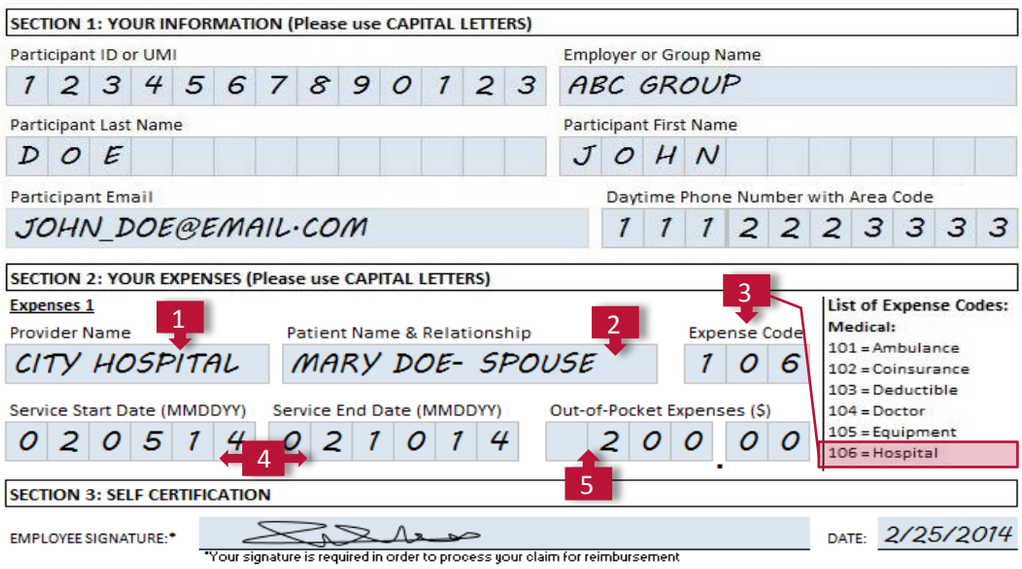
2. Patient name & relationship to participant

3. Medical expense code from list to the right

4. Service start & end dates

5. Your out-of-pocket expenses. These are the costs you paid.

• Read the certification of Section 3 and Sign and date the form



Acceptable Supporting Documentation:

• Copy of Explanation of Benefits(EOB) from your insurance company

• Copy of detailed receipts from your pharmacy, medical, dental or vision provider. Your receipts must show:

- The date you received the service or the date you made a purchase.
- Service type or product name. Check eligible service or product list online. Some products and services require a letter of medical necessity from your doctor for example massage therapy or wellness service.
- Amount charged to patient clearly showing the patient's responsibilities.
- Doctor or service provider name

Unacceptable Supporting Documentation:

• Credit or debit card receipts, canceled checks or other payment statements are not accepted as support documentation.

• Documentation showing a previous balance or Balance forward amount

• Prepayments, pretreatment estimates or estimated insurance statement are not acceptable documentation.

• Original receipts or supporting documentations. Keep originals for yourself and send copies.

Notes:

• **While submitting any Orthodontia claims** for the first time, please submit the orthodontia contract from the orthodontist along with any proof of payment (such as Credit Card receipt, Cancelled Check etc.).

• **Receipts for over-the-counter (OTC) medications or items** must show the purchase date and the name of the medicine or item. Please circle the expense on your receipt. A valid prescription is required for most of the OTC medications (for example Cough & Cold drops, Pain relief drugs, allergy medicine) to get approved. But for insulin, diabetic supplies, OTC medical devices (crutches, blood sugar monitors, blood pressure monitors), bandages, contact lens solutions, etc. don't need prescriptions.

Flexible Spending Account Claim Form

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or Mail to: Spending Account Processing, PO Box 25173, Lehigh Valley, PA 18002-5173

Go Paperless! You won't need to complete paper forms anymore. Submit online and expedite reimbursement.

SECTION 1: YOUR INFORMATION (Please use CAPITAL LETTERS)

Participant ID or UMI

Employer or Group Name

Participant Last Name

Participant First Name

Participant Email

Daytime Phone Number with Area Code

SECTION 2: YOUR EXPENSES (Please use CAPITAL LETTERS)

Expenses 1

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

Expenses 2

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

Expenses 3

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

Expenses 4

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

More expenses? Please complete another claim form.

List of Expense Codes:

Medical:
101 = Ambulance
102 = Coinsurance
103 = Deductible
104 = Doctor
105 = Equipment
106 = Hospital
107 = Laboratory
108 = Pharmacy Prescription
109 = Related Travel
110 = Therapy
111 = Over The Counter (OTC)

Medical - Preventative:
201 = Immunization
202 = Physicals
203 = Screening
204 = Smoking Cessation
205 = Weight Loss

Dental:
301 = Equipment
302 = Examination
303 = Orthodontia
304 = Over The Counter Medication
305 = Pharmacy Prescription
306 = Treatment

Vision:
401 = Equipment
402 = Examination
403 = Over The Counter Medication
404 = Pharmacy Prescription
405 = Treatment

SECTION 3: SELF CERTIFICATION

I certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the program, and that these expenses have not been reimbursed or are not reimbursable under any other plan/program. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I agree to abide by the terms of the program and have read the information on this form. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

EMPLOYEE SIGNATURE:* DATE:

*Your signature is required in order to process your claim for reimbursement