



MedBen Group # _____

MedBen Benny™ Debit Card Receipts
Debit Card Substantiation Form – Submittal of Receipts

Employee Name: _____ SS # _____

Street Address: _____

Instructions: The participant must provide supporting documentation from an independent third party, which includes the following:

- A bill or receipt (including date of service, name of patient, provider name-address, amount, and type of service) from a doctor, dentist, or other supplier;
- A prescription receipt (including the date prescription was filled, name of patient, pharmacy name-address, amount, and prescription name) from a pharmacy;
- Explanation of benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by the medical/dental/vision plan(s) under which the employee or any eligible dependents are covered; or
- A bill or receipt (including date(s) services were provided, name of dependent, child care provider name-address-phone number, amount, Tax ID number or Social Security number) from a childcare provider.
- Store receipts are acceptable **ONLY** for hearing aid batteries, contact solution and over the counter medications. The receipt **MUST HAVE** the following information printed on the receipt: Store name, date of purchase, Product name and amount of product.

Please do not submit proof of payment in the form of a non-itemized cash/credit card/or debit card register receipt, as these do not provide the IRS required substantiation.

Send this form along with your supporting documentation to: MedBen, Specialty Services Unit, P. O. Box 1096, Newark, OH 43058-1096.

To the best of my knowledge and belief, my statement in this Debit Card Substantiation Form is complete and true. I certify that I or my family member has received the services described above on the dates indicated, that the expenses qualify as valid expense under the FSA Plan, and that I have not been reimbursed previously under the Employers Plan or any other Health plan, FSA plan or HRA plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is for prescription or over the counter drugs, I certify that such drugs are not for cosmetic purposes. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. I understand that if the expenses are deemed ineligible for reimbursement under the Employers plan that it is my responsibility to reimburse the plan immediately for the ineligible portion of the transaction. I also understand that if the card is used again for an ineligible expense, the Debit Card will be suspended for the remainder of the plan year. In this event, you must obtain future reimbursements by submitting a manual request for reimbursement form along with the appropriate receipt(s).

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).

Employee Signature

Date

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