Group #

FLEXIBLE BENEFIT PLAN (FSA)
REIMBURSEMENT REQUEST FORM

This form should NOT be used to substantiate Benny debit card transactions requests or Health Reimbursement Arrangement (HRA) claims.

EMPLOYEE INFORMATION	ML: 22
Employee Name:	PID #
Address, City, State, Zip:	Is this a new address? _____ Yes or No

MEDICAL CARE REIMBURSEMENT PLAN (Health or Limited Purpose FSA) Please copy form or attach itemized list if you need more space

Date Medical Care / Service Was Actually Provided	Name of Person Receiving Medical Care / Service & Relationship to You	Type of Service	Reimbursement Amount Requested
			$
			$
			$
			$
			$

Total Medical Care Reimbursement Requested $ _____

DEPENDENT CARE REIMBURSEMENT PLAN - Please copy form or attach itemized list if you need more space.

Date or Date Range Care Was Actually Provided	Name of Dependent	Dependents Relationship to You / Age	Provider or Care Giver's Name	* Provider or Care Giver's Tax ID # or SSN # (required)	Reimbursement Amount Requested
					$
					$

** Dependent Care Reimbursement requests **will not be processed** without the Tax ID or SSN of the Provider or Care Giver.*

Total Dependent Care Reimbursement Requested $ _____

DEPENDENT CARE PROVIDER OR CARE GIVER INFORMATION
(If there is no itemized receipt available, this section **must** be completed by the Dependent Care Provider or Care Giver)

Provider/Care Giver Name:	Tax ID or SSN #
Address, City, State, Zip:	
I certify that I have provided the services listed above. Provider/Care Giver's Signature:	Date:

To the best of my knowledge and belief, my statement in this Reimbursement Request Form is complete and true. I certify that my family member or I have received the services described above on the dates indicated, that the expenses qualify as valid medical or dependent care expenses under the Plan. I certify that these expenses have not previously been reimbursed under my Employer's Plan or any other Health plan, FSA plan, HSA Plan or HRA plan, nor will I seek reimbursement for any of these expenses elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **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).**

Signature (Required):	Date:

Specialty Services Unit • 1975 Tamarack Road • P.O. Box 1096 • Newark, OH 43058-1096
FSA Phone (800) 297-1829 • Fax (740) 522-7483 • www.medben.com • email: admin@medben.com

Medical Care Reimbursement Account (Health FSA):
Examples of expenses for which you may be able to receive reimbursement include:

- Medical and Dental expenses not covered under any other plan
- Deductibles, co-payments and co-insurance that you are responsible for under your primary medical, dental or vision plan, or under any other plan
- Prescription drugs and medications (including over the counter drugs or medicines as long as there is a bona-fide prescription for the medication)
- Eye exams, eyeglasses, contact lenses, and other vision expenses
- Orthodontic expenses
- Hearing exams, hearing aids, other hearing expenses
- Physical therapy (not massage therapy)
- Chiropractics
- Acupuncture
- Psychotherapy

Limited Purpose Medical Care Reimbursement Account (Limited Purpose FSA):
Examples of expenses for which you may be able to receive reimbursement include:

- Dental expenses not covered under any other plan (non-cosmetic)
- Deductibles, co-payments and co-insurance that you are responsible for under your primary dental or vision plan
- Eye exams, eyeglasses, contact lenses, and other vision expenses
- Orthodontic expenses
- Eyeglasses, contact lenses, contact lenses solution
- Sunglasses (as long as the lenses' are a prescribed lenses)

Dependent Care Reimbursement Account:
Each person for whom you incur the expenses must be a Qualifying Individual - that is, he or she must be:

- a person under age 13 who is your "qualifying child" under the Code. In general, the person must:
  (1) have the same principal place of residence as you for more than half the year;
  (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and
  (3) not provide more than half of his or her own support for the year;
- your Spouse who is physically or mentally incapable of self-care and has the same principal place of residence as you for more than half the year; or
- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of residence as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

Required Supporting Documentation:

- A bill or receipt (including date of service, name of patient, provider name and 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 and 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;
- Store receipts are acceptable for hearing aid batteries, contact lens solution, support braces, reading glasses and other eligible over-the-counter items. The receipt MUST HAVE the following information printed on the receipt: Store name, date of purchase, product name and amount of product;
- To obtain reimbursement for OTC medications, a copy of a prescription for the medication will have to be submitted either prior to or at the time of filing the claim for reimbursement. A "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.
- A bill or receipt (including date(s) services were provided, name of dependent, provider name and address, phone number, amount, Tax ID number or Social Security number) from a childcare or adult care provider; or
- A completed Dependent Care Receipt for Services Form from a childcare or adult care provider.

Cancelled checks, handwritten receipts, credit/debit card transaction receipts or previous balance receipts cannot be used to verify an expense. We suggest that you keep your itemized receipts in one place so they're readily available when you receive a request.