MedBen Group #_____

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

Employee Name: _____ SS # _____

Street Address: _____

Instructions: IRS regulations require that an employee furnish a written statement stating that the expense they are requesting reimbursement on has been incurred and they have not been reimbursed nor will they seek reimbursement under the Health Benefit Plan or any other Health Plan, Flexible Spending Plan, Health Reimbursement Arrangement Plan, or Health Savings Account Plan. The Participant does not have to prove the services were paid for; they only have to prove the services were incurred during the applicable Plan Year. 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;
- 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 drugs or medicine, a copy of a prescription for the drug or medicine must 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.

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 their itemized receipts in one place so they're readily available when you receive a request.

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).

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Employee Signature Date