BeneFLEX HR RESOURCES INC.

Download current claim form at www.beneflexhr.com

FSA Plan Reimbursement Claim Form

EMPLOYEE INFORMATION

Name: ______________________ Last four digits of your Social Security#: ___ ___ ___ ___
Address: ______________________ Company Name: ______________________
City/State/Zip: ______________________

☐ **Please check box if address is new**

Dependent Care Reimbursement

Name of Dependent	Service period From	Service period To	Name, Address, Taxpayer identifier number of provider of service	Charge of Service
	Total Dependent Care Amount Requested: →			**$**

I provided the dependent care as stated above. ______________________ ____________ ____________
Provider's signature Date SSN/Tax ID

Flexible Medical Benefits

Patient's Name	Type of Services Please check One Box Below for Each Expense Type MD=Medical, Rx=Prescription, DN=Dental, VS=Vision OTCS=Over-the-Counter Supplies **OTCD=Over-the-Counter Drug (Must include Rx along with receipt)**	Date(s) of Service mm/dd/yyyy		Healthcare Mileage* $0.24 per mile**	Amount of Charge
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	MD ☐ RX ☐ DN ☐ VS ☐ OTCS ☐ OTCD ☐	From:	To:		
	NOTE: EVERY OTC DRUG CLAIM REQUIRES A COPY OF THE PRESCRIPTION TO BE ATTACHED.	Total Medical Amount Requested: →			

Please arrange documentation in order listed above.

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed were incurred during the current period under the company's Cafeteria Plan. The undersigned participant in the Plan understands that expenses are "incurred" when a service is performed or care is provided, not when the bill is paid. The undersigned certifies that all expenses for which reimbursement or payment is claimed on this form were incurred on the dates of service stated above. The undersigned fully understands that he or she is alone fully responsible for the sufficiency, accuracy, and veracity of all the information relating to this claim and unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State, or City income tax on amounts paid from the Plan which relate to such expense.

______________________________ ______________
Employee's Signature (must be signed for proper processing) Date

To Submit a claim: Visit us at: www.beneflexhr.com and login into your account or send your claim form along with all supporting documentation directly to BeneFLEX via email: info@beneflexhr.com, fax: 314.909.6983 or mail to: 10805 Sunset Office Drive., Ste. 401, St. Louis, MO 63127.

Please note: Please do not submit a claim for reimbursement if you used your Benny Card.
Claim Submission deadline is Tuesdays at 3:00 p.m. CST 1:00 p.m. PST. BeneFLEX issues checks on Thursday.
**Mileage to and from provider to your home. **If rate has changed, amount will be adjusted at processing.*

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

GUIDELINES FOR CLAIMS SUBMISSION: *The Internal Revenue Code provides the following guidance:*

Medical Reimbursement

- The best receipt is an ***Explanation of Benefits*** from your insurance company.
- If other receipts are submitted, they must show the following information:
  1. Who rendered the service (name and address)?
  2. What type of service was rendered?
  3. Date service was provided, *not a billing or due date.*
  4. Amount of charge.
  5. Any insurance payment, if applicable.

  Cancelled checks and credit card slips are not allowable receipts.

  NOTE: In order to process your claim all 5 pieces of information must be on each receipt.
  (This includes receipts for orthodontic services)
- Any amount claimed which is a 'Previous Balance' or 'Balance Forward', etc. cannot be paid unless the information stated in items 1-5 above is shown on the receipt.
- Receipts must show all expenses incurred. Any over-payment, pre-payment, etc., for which no services are listed, cannot be reimbursed.
- **Over-the-Counter (OTC) drugs with doctor's prescription and all other OTC items**
  1. When and Who Sold the product (date, name, and address)?
  2. Type of OTC was purchased? *Must show product or brand name.
  3. Amount of charge.
  4. **NOTE: EVERY OTC DRUG CLAIM REQUIRES A COPY OF THE PRESCRIPTION TO BE ATTACHED.**

Eligible Items Subject to Change See Current List at www.beneflexhr.com

* If the receipt does not show the name of the product you can write the product name on the receipt. You must have the cashier verify by signing their name. **Canceled checks and credit card slips are not allowable receipts.**

- **Mileage Reimbursement**
  Mileage incurred to and from your home or office to receive medical care is reimbursable through the FSA at the rate of $0.24 per mile. If rate has changed, amount will be adjusted at processing.
  Mileage claim must include substantiation (i.e. provider invoice, receipt, etc.).

Dependent Care Reimbursement

- Cancelled checks are acceptable. Please include a copy of the front & back of the check, the dates of service, and the facility federal ID number or the social security number of the individual providing service.
- All receipts must show the following information:
  1. Who rendered the service (name and address)?
  2. What type of service was rendered?
  3. Date of original service, *not a billing date.*
  4. Amount of charge.
  5. Federal ID number (facility) or social security number (individual).

For Your Reference

- Scheduled processing date(s): Weekly or Daily (company specific)
- To ensure you are reimbursed, all claims must be received by BeneFLEX HR Resources, Inc. no later than 3:00 p.m. (central) 1:00 p.m. (pacific) Tuesday for weekly processing.
- BeneFLEX phone numbers - (314) 909-6979 and (800) 631-3539 (outside St. Louis) or fax number (314) 909-6983.
- If you terminate employment, any expenses incurred after your termination date are not eligible for reimbursement. Medical Expenses can still be claimed if you continue your participation under COBRA.
- If you fax your claim, keep a copy of the confirmation statement in case BeneFLEX does not receive your paperwork.
- Please itemize the expenses on your claim form.
- You can contact BeneFLEX HR Resources, Inc. by e-mail at info@beneflexhr.com or visit us online for up-to-date information such as Frequently Asked Questions, download forms, e-mail questions to our team members, articles on changes in the Cafeteria Plan regulations.

Check Your Account Balance

- Visit us online at www.beneflexhr.com, click on "Employee" and then select "Employee Login".
- Use our Voice Account System by calling 314.909.6979 or toll free 800.631.3539 (outside St. Louis) press #2 and listen for the prompts.