



FSA/HRA REIMBURSEMENT CLAIM FORM (Please Print Clearly)

PART 1		PART 2 <input type="checkbox"/> Check here if address has changed and provide new information below.		
Employee Name:		Street or P.O. Box:		
Member ID:		City:		
Employer:		State:		Zip Code:
PART 3				
Provider & Service Rendered/Item Purchased	*Pay from Prior PY?	Date(s) of Service	Amount	For Office Use Only
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
	<input type="checkbox"/> YES			
TOTAL →				
		Signature Required: _____ Date: _____		
ATTN: Claims Department Benefit Resource, Inc. 2320 Brighton-Henrietta TL Rd. Rochester, NY 14623-2782 Fax: (585) 427-9320				
Employee Certification: By signing the above, I request reimbursement for Medical and/or Dependent Care expenses listed above. Enclosed are itemized bills, receipts or EOBs verifying these expenses. Each expense listed is for a service/item provided to me, my spouse or an eligible dependent, has not been purchased with a Beniversal® card, and will not be reimbursed from any other source. Medical expenses were incurred only for an immediate medical purpose. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and cannot be claimed as deductions on my personal income tax.				

*If your Plan offers the extended grace period allowed by IRS regulations, you must check Yes if you wish to have this expense reimbursed from the prior Plan Year.

INSTRUCTIONS FOR SUBMITTING YOUR CLAIM:

- Part 1 of the claim form *must* be completed in full.
- Part 2 of the claim form should only be completed if your address has changed.
- Part 3 of the claim form *must* be completed in full.
- For each item you are claiming in Part 3, you must attach a copy of itemized bills, statements, receipts or insurance company Explanation of Benefits (EOBs). This documentation from your provider *must* include the following information (please retain originals for your personal records).
 - Name of provider
 - Date(s) service was provided
 - Type of service provided (for prescriptions, must include name of drug)
 - Your out-of-pocket cost for the service
 - Name of person receiving the service

IRS regulations may require additional documentation for certain expenses (e.g. for dual purpose items).

- The claim form *must* be signed and dated after reading the Employee Certification.
- Submit the completed claim form and related documentation to:

ATTN: Claims Department
Benefit Resource, Inc.
2320 Brighton-Henrietta TL Rd.
Rochester, NY 14623-2782
Fax: (585) 427-9320

CLAIM SUBMISSION REMINDERS:

- Credit card statements, cancelled checks and balance forward/prior balance statements *are not* acceptable.
- The service being claimed must be provided within your Plan Year to you, your spouse or your dependent.
- In general, IRS regulations do not require that you pay for a service before requesting reimbursement. A request for reimbursement must be based on the date when the service was provided, not the date when a payment was made. (The IRS allows one exception: orthodontia expenses can be based on date of payment, date of service or payment due date on statements/coupons.)
- Claims must be submitted *after* a service is provided, but *before* the end of the run-out period following the end of your Plan Year.
- Claims must be received by Benefit Resource, Inc. within the timeframes specified in the Plan Highlights.
- The expense being claimed cannot be reimbursed from any other source.

SOME EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT INCLUDE:

- Personal care items (e.g. shampoo, soap, electric toothbrush, toothpaste, mouthwash)
- Teeth whitening
- Insurance premiums

SOME EXPENSES ARE ONLY ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT IF CERTIFIED BY A LICENSED MEDICAL PROVIDER AS PREVENTING, TREATING, OR MITIGATING A SPECIFIC PHYSICAL DEFECT OR ILLNESS:

- Cosmetic services
- Vitamins
- Nutritional and dietary supplements
- Non-prescription sunglasses
- Exercise and weight loss programs

