



**FSA/HRA REIMBURSEMENT CLAIM FORM** (Please Print Clearly)

<b>PART 1</b>		<b>PART 2</b> <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:
<b>PART 3</b>				
<b>Provider &amp; Service Rendered/Item Purchased</b>	<b>*Pay from Prior PY?</b>	<b>Date(s) of Service</b>	<b>Amount</b>	<b>For Office Use Only</b>
	<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			
	<input type="checkbox"/> YES			
<b>TOTAL →</b>				
		<b>Signature Required:</b> _____ <b>Date:</b> _____		
<b>ATTN: Claims Department</b> <b>Benefit Resource, Inc.</b> <b>2320 Brighton-Henrietta TL Rd.</b> <b>Rochester, NY 14623-2782</b> <b>Fax: (585) 427-9320</b>				
<b>Employee Certification:</b> 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

