

Request for Reimbursement Form

Employee name _____ ID or SS # _____ Employer _____

Home address _____
 Number/Street City State Zip Daytime phone _____

HEALTH FSA/HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Health FSA: All claims must be submitted with supporting documentation containing the following:

- **Name of patient**
- **Name and address of provider**
- **Expense incurred (type of service)**
- **Date of incurred expense (the date the service is provided, not when the expense is paid)**
- **Amount of expense**
- **Amount insurance paid, if applicable**

If the request is for an over-the-counter (OTC) expense, you must indicate the name of the drug and its purpose to treat the patient. All claims for OTC drugs must be accompanied by an itemized receipt. Please see the reverse side for documentation requirements. If your insurance carrier, HMO or health care plan administrator will be processing any of these charges, attach a copy of the Explanation of Benefits from the insurance carrier containing all the supporting documentation listed above.

HRA: Your HRA Plan may be limited to the types of health care expenses that may be reimbursed to you. For a list of eligible expenses, please read your HRA Plan's Summary Plan Description (SPD).

Date of Service From m/d/y to m/d/y	Expenses for		Account type		Description of service (i.e., medical, dental, vision, Rx)	Over-the-counter (OTC) drug name	OTC drug – purpose to treat patient (allergies, sickness, etc.)	Amount of reimbursement request
	Patient name	Relationship	FSA	HRA				
/ / to / /								
/ / to / /								
/ / to / /								

Amount of request: \$ _____

Benny card used for this claim Yes No

DEPENDENT CARE FSA

Submit dependent care claims using one of the methods below:

1. Complete FSA Request for Reimbursement Form and have dependent care provider sign and date. Submit to Infinisource, Inc. for reimbursement.
2. Complete FSA Request for Reimbursement Form and attach supporting documentation which must include: **provider name and address, dependent name(s), dates of service and amount of expense.**

A signed and dated reimbursement form must accompany every claim.

Date of service From m/d/y to m/d/y	Dependent name	Relationship	Age	Name of care provider	Amount of reimbursement request
/ / to / /					
/ / to / /					
/ / to / /					

Amount of request: \$ _____

I certify that I provided care as specified above.

Dependent care provider signature *(Necessary only if a receipt is not provided.)* _____

Date _____

I certify that:

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ol style="list-style-type: none"> 1. The above listed expenses have been incurred by me, my spouse or my eligible dependents (as defined by the IRS). 2. All applicable insurance or other medical plan benefits have been exhausted. 3. Listed OTC expenses are to treat a medical condition. 4. I will not deduct these reimbursements as a tax credit on my federal income tax return. I have not been reimbursed for, and will not seek reimbursement of, the above listed expenses under any other plan covering such expenses. 5. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions. | <ol style="list-style-type: none"> 6. I have received the taxpayer ID# of my dependent care provider. I understand that I must provide this information on my federal income tax return. 7. All services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the company's FSA and/or HRA with respect to such expenses. 8. To the best of my knowledge, all statements on this form are true, correct and complete. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Employee signature (You must sign this form to be reimbursed.)

 Date

I participate in both the HRA and the Health FSA and want Infinisource, Inc. to process my health care claims under both benefits.
Infinisource has incorporated the HIPAA Privacy Requirements to reflect our organization's business practice regarding your insurance coverage



INSTRUCTIONS AND DOCUMENTATION REQUIREMENTS FOR FSA AND/OR HRA REIMBURSEMENT

Claim confirmation: You can easily view your claim status 24 hours a day, 7 days a week at www.infinisource.net (Choose FSA or HRA Participant from the Login drop-down menu). If you choose to mail your claim, please do not fax the same claim. Claims may be faxed to 800-379-5670. Keep the fax confirmation for your records. If faxed, allow two business days before checking the website or calling for the status of your claim.

Please read these instructions before completing the front of this form.

1. Complete all required information on the Reimbursement Form.
2. Sign and date the form.
3. Attach appropriate documentation.
4. Keep copies of this form and the documentation for your tax records.
5. Mail or fax to Infinisource.

You must sign and date the claim form and attach a copy of a bill, invoice or other written statement from a third party containing the patient name, provider name and address, a description of each expense, the date it was incurred, the amount of the expense and the amount insurance paid, if applicable. The IRS does not allow check copies, charge slips, "balance forward" and/or "previous balance" statements as acceptable documentation. (For orthodontia requirements, see item #3 below.) You may combine family members on one form. You must supply separate reimbursement forms for different plan years.

Documentation requirements for Health Care expense reimbursement:

1. For **medical or dental** expenses that will be processed by your medical plan, please submit the expenses to your medical plan administrator or insurance carrier first. Then submit copies of this form and the Explanation of Benefits containing all the supporting documentation listed above. Proof of expense payment is **not** required.
2. If you do not have medical plan coverage for **dental** or **vision** expenses, submit an itemized statement from your service provider showing the patient name, provider name and address, date of service, description of service and amount charged. To be reimbursed for contact lens solutions and cleaners, you may submit a cash register showing a description of the item. If the cash register receipt does not describe the item, provide a copy of the package indicating the price and product name.
3. **Orthodontia:**
 - **If your plan prohibits advance payment for orthodontia expenses**, please submit a copy of the Truth in Lending Statement, orthodontia contract or financial agreement with your initial submission itemizing the treatment period, down payment, monthly payment amount and the amount covered by insurance, if any. If this will be a recurring expense, please indicate and payment will be automatically made on a monthly basis.
Submit a copy of your monthly payment coupon and/or an itemized receipt each time you request reimbursement for ongoing treatment.
NOTE: The plan can reimburse orthodontia expenses paid in advance. The payment date determines the plan year.
Any additional fees such as x-rays, molds, etc., are reimbursable when incurred. The banding fee (fee paid for attaching brackets/bands on teeth) can be paid in full when incurred. Down payments are reimbursed after they have been made and banding has taken place. Please submit an itemized receipt showing down payment.
 - **If your plan allows advance payment for orthodontia expenses, please submit a copy showing payment for orthodontia.**
4. For **prescriptions**, submit a copy of the receipt showing the patient name, drug name, date the prescription was filled and co-payment amount charged. Cash register prescription receipts or charge slips showing the prescription and the amount charged cannot be accepted, as the patient name and drug name or number are required.
5. For **over-the-counter (OTC) expenses** you must indicate the drug name and its purpose to treat the patient. All claims for OTC drugs must be accompanied by an itemized receipt. If you submit a cash register receipt, it must include: provider name and address (drug or grocery store), purchase date, OTC expense name (if the drug/medicine name is not on the cash register receipt, you must submit a portion of the packaging with the drug/medicine name and price with the cash register receipt). Please note: some OTC drugs are not eligible for reimbursement unless a specific medical condition exists. If your reimbursement request is for one of the ineligible drugs listed below, the request must include a physician recommendation for the purchase and a listing of the medical condition.
 - Drugs purchased for cosmetic reasons (Rogaine, etc.)
 - Weight loss drugs
 - Drugs purchased for general health reasons (vitamins, etc.)
6. For other expenses, always submit itemized statements. A letter of medical necessity may need to accompany some charges (i.e., massage therapy, capital improvements and cosmetic procedures).

Documentation requirements for Dependent Care reimbursement:

Options for reimbursement as listed on front.

- Complete FSA Request for Reimbursement Form and have dependent care provider sign and date. Submit to Infinisource for reimbursement.
- Complete FSA Request for Reimbursement Form and attach supporting documentation which must include: **provider name and address, dependent name(s), service dates and amount of expense**. A cancelled check alone is insufficient documentation.

IMPORTANT:

- Claims must be fully incurred before reimbursement. Except as indicated above, Infinisource cannot process claims for future dates of service.
- Some expenses associated with dependent care are not eligible, including overnight camp, food and transportation costs. If you are submitting charges for a day camp, please make sure the documentation shows that it is a day camp.
- You must provide the IRS with the name, address and tax ID (or Social Security Number) of the dependent care provider on your federal income tax return. If you are unable to provide this information, the IRS may deny the exclusion for the dependent care spending account.

Claims appeal: If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time as described in the denial notice in which to request a second review by the Plan Administrator. You will be notified in writing of the reviewed decision as soon as reasonably possible but no later than 60 days after the request for review is received. Your Summary Plan Description outlines this in more detail.