Claim Form – FSA Medical Recurring Expense

beneliance

This form is used to request ongoing reimbursement from your Flexible Spending Account (FSA) for recurring, eligible medical expenses. By completing this form you will not need to provide continuing documentation. Please complete all fields and include appropriate documentation showing the expense you will be charged throughout the year or during specific time frames.

All information must be completed for you to receive reimbursement.
CLAIMS WILL NOT BE PROCESSED WITHOUT YOUR SIGNATURE.

A. Declaration of Services

I request reimbursement for the below listed time frame for FSA-qualified medical care services. I certify that the expenses are for dates of service between the following:

Start Date (mm/dd/yyyy)_____ End Date _____

I have included signed copies of the provider's charges, in the total amount _____ of $ for the dates indicated above.

NOTE: If you have any changes during the dates referenced above, please notify Beneliance at (877) 685-0655 or email benefits@beneliance.com

B. Employee/Participant Information

Employer Name (Please Print) _____

Employee/Participant Last Name _____ First Name_____ MI ____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone ( ) _____ Work Phone ( ) _____

Participant Email Address _____

C. Provider Information

Name of Service Provider _____

Name of Claimant (Person Receiving Service) _____

Provider Address _____ City _____ State _____ Zip _____

Provider Account/Claim Number (if applicable) _____

D. Certification and Signature

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or eligible dependents) and were not reimbursed by any other plan, nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Flexible Spending Account (FSA). I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee/Participant Signature _____ Date ____/____/____
mm/dd/yy

For fastest processing, fax to 855-445-1696 or email to support@beneliance.com

Beneliance | PO Box 55068 Little Rock, AR 72215 | Toll-Free 877-685-0655
Toll-Free Fax: 855-445-1696 | support@beneliance.com | beneliance.com