Claim Form - Health FSA Reimbursement or Card Substantiation

☐ Please check here if new mailing address

☐ Please check here if new email address

Section 1: Empl	loyee In	formation
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Employer Name	(Please Print)					
Employee Last Name			First Name	Middle	Middle Initial	
Address				State	Zip	
Social Security Number			Home Phone () _	Work Phone ()	
Employee Email	Address					
Section 2: Cl	aim Informat	ion sement Account R	ules and Claim Filing Instrution below must be compl	uctions before completinย	g this claim.	
Debit Card Purchase?	Service Date (mm/dd/yyyy)	Patient Name & Relationship	Provider Name & Address	Description of Service	Amount	
☐ Yes ☐ No					\$	
☐ Yes ☐ No					\$	
☐ Yes ☐ No					\$	
☐ Yes ☐ No					\$	
□ Yes □ No					\$	
☐ Yes ☐ No					\$	
				Total	\$	
I certify that to or my spouse knowledge are use the experienceme tax reor deceive an	Certification for the expenses for and/or eligible and belief, are ense reimburse eturn. I understy insurance co	e dependents), v ligible for reimbo d through this ac tand that any pe ompany, adminis	nt nt requested from my a vere not reimbursed by ursement under my Rei ccount as deductions or rson who knowingly and trator, or plan service p nformation may be guilt	any other plan, and to a mbursement Plans. I (or credits when filing my or d with intent to injure, co rovider files a statemen	the best of my r we) will not (our) individual lefraud, it of claim	
Employee's Sig	nature			Date	/ / mm/dd/yy	

For fastest reimbursement, please submit claims via FAX, EMAIL or MOBILE APP

Beneliance | Toll-free: 877-685-0655 | Fax: 501-553-9097 PO Box 55068, Little Rock, AR 72215 | benefits@beneliance.com | beneliance.com

Claim Form - DCAP Reimbursement

		□ Please check here	e if new ma	iiling address □ Plea	se checl	k here if new email addre	SS		
<u>Employe</u>	<u>er</u> Nam	e (P l ease Print)							
Employe	<u>ee</u> Last	Name		First Name		Middle	Middle Initial		
Address				City		State	Zip		
Social Se	ecurity	Number		Home Phone ()	Work Phone ()		
Employe	ee Ema	il Address							
Please Use a d	read copy c			t Rules and Claim Filinរុ e space. All information			eting th	nis claim.	
Service F	Period To	Dependent Name	Age	Provider Name & Address		Provider Tax ID#/SS#	Am	ount	
							\$		
							\$		
							\$		
							\$		
							\$		
						Total	\$		
I certify or my s my kno not use individ insura incomp	y that spous owled e the o ual in nce co olete o	e and/or eligible de ge and belief, are el expense reimburse come tax return. Ar ompany, administra or misleading inforr	eimburse ependents ligible for d through ny persor tor, or pla mation m	ment ment requested from s), were not reimburse reimbursement unde n this account as dedu n who knowingly and w an service provider, file ay be guilty of a crimir	d by ai r my Ro ctions vith inte es a sta nal act i	ny other plan, and to eimbursement Plans. or credits when filing ent to injure, defraud, atement of claim cont punishable under law	the be I (or w my (ou or dec aining	st of re) will ur) ceive any false,	

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