

ELMS COLLEGE
Health Flexible Spending Account - Reimbursement Request Form
Plan Year: 7/1/2011 – 6/30/2012

Employee Name: _____

Address (Street, City, State, Zip): _____

Submit Claims To: BFP Associates – PO Box 478 West Springfield, MA 01090

Questions? Contact us at 413.739.2352, or email: kbradway@bfpassociates.com

Instructions: All areas below must be completed, if the form is incomplete it will be returned to you unprocessed. All expenses must be filed under your medical or dental insurance carrier before you request reimbursement from this plan. *Read the reverse side of this form for instructions and information.*

Health Flexible Spending Expenses: Please use 1 form for your request, subtotaled by dependent

	<i>Example</i>					
Name of Person Receiving Service(s)	<i>Sally Brown</i>					
Age and His/Her Relationship To You	<i>Age: 8 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependent</i>	Age: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Age: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Age: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Age: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Age: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Type of Service(s)	<i>rx copays, office visit copay, prescription glasses</i>					
Proof of Expenses Attached?	<i>X Yes <input type="checkbox"/> No</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Bills Attached	<i>5</i>					
Reimbursement Requested	<i>\$200</i>	\$	\$	\$	\$	\$
TOTAL REIMBURSEMENT REQUESTED						\$

I certify that:

- To the best of my knowledge and belief, my statements in this Form are complete and true, *AND I have read the reverse side of this form.*
- Either I or my family member has received the services described above, and the expenses are my out-of-pocket expenses that qualify as valid Medical Care Expenses under the Plan. If the expense is for my Spouse or Dependent, the person listed is my Spouse or Dependent as defined by the Plan.
- I have not been reimbursed previously for these expenses under the Plan. These expenses have not been reimbursed/ are not reimbursable under the major medical plan or any other health plan, such as my Spouse's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) that I am requesting reimbursement for must be incurred during my period of coverage.
- I will have until 9/15 of the following plan year to submit my claim for reimbursement for expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account in accordance with the IRS rules.
- The expenses that I am reimbursed may not be used to claim any federal income tax deduction or credit, or reimbursement under another medical plan or any other plan.

Employee Signature* _____

Date* _____

**Your signature and the date are required in order to process your claim for reimbursement*

For Office Use Only	Date processed	Check Number	Amount Denied	Amount Paid
Notes:		#	\$	\$

Reimbursement instructions:

1. Complete the information on the front side of this form for Health Care Expenses incurred by you, your Spouse or other eligible Dependents.
2. All expenses should be first filed with your medical or dental insurance carrier before you may request reimbursement from your Health Flexible Spending Account.
3. Read the employee's certification for reimbursement on the reverse side, sign and date form.
4. Claims will be processed within 10-12 business days, upon receipt in our office of all required documentation.
5. Submit this form and all required documentation to BFP Associates at the address on the front of this form.
6. This form is to be used to request reimbursement for Health Care Expenses.

In order to be reimbursed for health care expenses, you must complete the front side of this form, and attach either 1 or 2 below to this form:

1. Explanation of benefits (EOB)

This is the statement you receive each time your insurance carrier (medical or dental) processes a claim submitted to them by you or your medical or dental provider. This statement will state the total amount of the charges and the amount you owe. If you have medical and/or dental insurance, your claim must be submitted to the insurance carrier before you may request from this account.

2. Over the counter (OTC) items

Under the new health care reform legislation, over-the-counter (OTC) expenses will be eligible for reimbursement only if the request is accompanied by a doctor's prescription.

Over-the-counter expenses (such as cough medicines, pain relievers and acid controllers) incurred on and after January 1, 2011 will no longer be reimbursed unless there is a doctor's prescription submitted along with each reimbursement request.

3. All other expenses

Claims for expenses other than what you would receive an EOB for (prescription copays or office visit copays) must be itemized and must include the following;

- Type of service or product provided
- Date of service expense was incurred NOT PAID
- Patient's name for whom the service or product was provided
- Physician or organization who provided the service
- Physician or organization address and telephone number
- Amount of expense

Types of evidence not acceptable for reimbursement

The following items are not acceptable as documentation for reimbursement under this plan:

- Credit card receipt or credit card statements
- Debit card receipts or debit card statements
- "Previous balance" or "balance forward" billing
- Cancelled checks
- A bill from provider when you have medical or dental insurance and you owe more than copay amount, you must submit EOB
- Pre-estimate invoice
- Payment for services not yet incurred, but paid for