# HEALTH CARE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

**To fax completed form:** 316-268-9687 ● 800-538-0757 (do not also mail original)
**To mail completed form:** HARRINGTON HEALTH FLEXIBLE BENEFITS ● P.O. BOX 2697 ● WICHITA KS 67201-2697
**Questions?** Call 316.264.5311 ext. 38855 • 800.235.7160 option 2, option 2 (again)

## EMPLOYER INFORMATION

| Employer Name | ☐ **Check here if your address has changed** |
|---|---|
| | |

## EMPLOYEE INFORMATION [please print]

| First Name | Last Name | MI | Social Security Number |
|---|---|---|---|
| | | | |
| **Street address** | **City** | **St** | **Zip** |
| | | | |
| **Employee e-mail** | **Home phone** | **Daytime phone** | |
| | | | |

## INSURANCE INFORMATION

Current medical coverage: ☐ Harrington Health ☐ HMO ☐ BCBS ☐ Other medical:

Other current carriers: ☐ Dental carrier: ☐ Vision carrier:

(Please check as appropriate) I certify that I have **no** insurance coverage for the following benefits:

☐ MEDICAL ☐ DENTAL ☐ RX ☐ CHIRO ☐ HEARING ☐ ORTHODONTIA ☐ EYE EXAM ☐ EYEGLASSES/CONTACTS

**THIS FORM MUST BE COMPLETED & SUBMITTED WITH SUPPORTING CLAIM DOCUMENTATION TO RECEIVE REIMBURSEMENT**
(Canceled checks or credit card receipts are not acceptable forms of documentation.)

**● PLEASE KEEP A COPY OF ALL CLAIM FORMS AND RECEIPTS ●**

| SERVICE DATE (MM DD YYYY) | TYPE OF SERVICE (MED, DENTAL, OTC) | NAME | RELATIONSHIP (SP, CHLD, PARENT) | NAME OF PROVIDER OR MERCHANT | AMOUNT |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | **TOTAL REQUESTED:** | $ |

**Mileage Reimbursements** – The standard mileage reimbursement is $0.165 (or 16 1/2 cents) per mile traveled in 2010 ($0.24 per mile for mileage traveled in 2009) for use of an automobile to obtain medical care. Additional documentation may be required if your mileage reimbursement request is considered excessive by the administrator.

## PARTICIPANT STATEMENT

I certify that the amount of reimbursement requested was incurred during my coverage period for me and/or my eligible dependents(s). This/These is an/are eligible expense(s) for medical care under Code § 213(d) and is primarily for a medical purpose related to the diagnosis, cure, mitigation, treatment, or prevention of disease or illness and qualifies under IRS Section 125 guidelines. I have not been (nor will I be) reimbursed by any other sources for these expenses, and I will not be claiming it/them on my personal income tax return.

**Employee Signature / Employee Electronic Signature** **Date**

## Things You Should Know to Get Started

- The Health Care FSA reimburses eligible medical expenses for you, your spouse, and other qualified individuals. Certain over-the-counter medicines/items may be eligible if used for medical purposes. General health and cosmetic expenses, toiletries and vitamins/supplements are generally ineligible.
- Additional documentation may be required for personal and dual use expenses.
- The Limited Purpose FSA is designed to offer FSA coverage to employees who participate in a Health Savings Account (HSA). Covered benefits are generally limited to dental and vision service related expenses.

- The IRS requires third-party documentation showing the date of service, type of service, and out-of-pocket cost for each expense listed.
- Cancelled checks, credit card receipts, or statements showing only a balance due on your account are not acceptable types of documentation.
- Orthodontia expenses require detailed supporting documentation from your orthodontist/dentist. Expenses may qualify for payment reimbursement of:
    1. full upfront payment; or
    2. initial start up cost and/or subsequent monthly payments made throughout each plan year treatment period (excluding any interest, late payment fees and services charges).

  Please contact your FSA Plan Administrator to obtain your employer's plan reimbursement parameters.

## Submitting Your Claim

If you have insurance that covers part of the expense or your insurance does not cover the expense at all:

Submit the Explanation of Benefits (EOB) with your completed claim form. You do not need to submit any other documents with the EOB.

**NOTE**: Any third-party documentation that indicates insurance has not yet been paid (for example, pre-treatment estimate) will be returned to you. You will need to resubmit the claim once you have received a final EOB. The EOB must show that the insurance carrier has paid its portion of the claim.

Below are instructions for submitting a claim for prescription medication (or if you do not have insurance coverage).

Submit the itemized receipt or statement from the doctor/health care professional. The itemized receipt or statement must include:

- Provider name and address
- Patient's name
- Dates of service
- Types of service
- Dollar amount charged

**NOTE:** A receipt from doctor/other health care professional must clearly document patient's financial responsibility.

## Examples of Expenses (for more examples, visit irs.gov or call the Plan Administrator)

- Acupuncture
- Braces (not orthodontia)
- Braille books and magazines in excess of cost for regular editions
- Chiropractor fees
- Deductibles & co-payments (medical & dental)
- Dental/Orthodontia fees (non-cosmetic)
- Dentures
- Drug dependency treatment
- Expenses in excess of plan allowance
- Eyeglasses and contact lenses, solutions and enzyme cleaners
- First aid kits
- Hearing care and aids
- Immunizations
- Insulin
- Lasik surgery
- Medical mileage
- Osteopath fees
- Over-the-counter drugs and medicines approved by the IRS**
- Prescription drugs (including birth control if plan allows)
- Prostheses
- Radial Keratotomy surgery
- Routine physical exams
- Smoking cessation programs and prescriptions
- Special equipment (such as auto hand controls for a handicapped person)
- Temporomandibular Joint Dysfunction syndrome (TMJ) surgery and outpatient treatment
- Therapy treatments**
- Wigs when necessary for mental health of individual who loses hair due to disease**

**Requires letter of medical necessity

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