HealthSmart Benefit Solutions

HealthSmart Benefit Solutions
PO Box 241389, Apple Valley, MN 55124
Customer Service 844.516.3658

Reimbursement Request Form

Flexible Spending Account

☐ Check here if address has changed.

PART 1. EMPLOYEE INFORMATION (Please Print)

Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy)	SS # or Member ID
Address (Street, City, State, Zip)		
Email	Phone	Employer Name

PART 2. HEALTH CARE EXPENSES

DESCRIPTION OF EXPENSE AND REIMBURSEMENT AMOUNT REQUEST. Please Place Each Expense on a Separate Line.

Patient Name	Relationship to Account Holder*	Dates of Service		Description of Service	Provider of Service	Reimbursement Amount Requested
		From	To			

*Qualifying Relationships: Self, Spouse, Qualifying Child, Qualifying Relative

Total Reimbursement:	$

PART 3. EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses requested from my reimbursement account were incurred by me (and/or my eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement. I will not use the expenses reimbursed as deductions or credits when filing my income tax return.

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

Signature _____ Date _____

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Employee Instructions

Please read these instructions before completing the Reimbursement Request form.

Step 1

Complete all areas of Part 1: *Employee Information*.

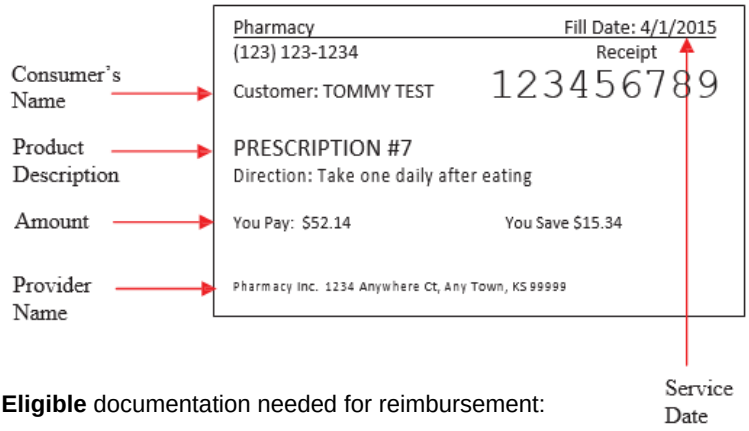
Step 2

Complete all areas of Part 2: *Health Care Expenses*, for medical, dental, vision, non-OTC medical products and prescription expenses. Please enter each expense on a separate line. Attach any supporting documentation to this form. The IRS requires than an Explanation of Benefits, or an itemized statement, be provided in order to substantiate your expense request.

1. Name of person receiving the services, and their relationship (Self, Spouse, Qualifying Child, or Qualifying Relative) to the account holder.
2. Date the service was provided
   - The medical service must be incurred during the plan year. (Claims for future dates of service(s) incurred to prior to the plan year are not eligible for reimbursement).
3. Description of service
   - The description of the service(s) must be provided. The description may be as generic as "co-pay" or "office visit."
   - Drug name and prescription # (if applicable).
4. Merchant name or facility provided the services.
5. Total out of pocket expense for the service(s).

Ineligible receipts include: credit card slips, bank statements, cancelled checks, and generic receipts.

Example of a Valid Receipt



Example of an Invalid Receipt

Eligible documentation needed for reimbursement:

OTC medicines or drugs: Requires a valid doctor's prescription and the cash register receipt which includes: a) the name of the provider or merchant, b) date of purchase, c) OTC item, and d) amount of the expense.

Insulin or diabetic supplies: Eligible without a prescription.

Non-OTC supplies: Receipt must include: a) the name of the provider or merchant, b) the date of purchase, c) description of the product, d) amount of the expense, and e) a copy of the label or packaging of product.

Documentation for medical, dental, vision and prescription expenses must include: a) name of person who incurred the service, b) date of service, c) description of service, d) merchant name or facility providing the service(s), and e) total out of pocket expense for the service.

Preferred documentation includes an *Explanation of Benefits* or *an itemized statement* from the provider, with all necessary information.

Step 3

Read Part 3: *Employee's Certification for Reimbursement*. Sign, and date the form where indicated.

Step 4

There are three ways to submit your claim(s) to HealthSmart:

1) **Self Service Portal:** https://healthsmart.wealthcareportal.com and login to the member's portal site. In order to submit your claim via HealthSmart's secure portal site, you will need your Member ID or Social Security number. If you do not have your User ID and password, contact Customer Service: 844.516.3658
2) **Mobile application**: HealthSmart My Flex Spending
3) **US Mail**: P.O Box 241389, Apple Valley, MN 55124