



HEALTH CARE SPENDING (HEALTH FSA) REIMBURSEMENT REQUEST FORM

Employee Name: _____ SS#: _____

Address: _____

Instructions: Complete the information below for medical expenses incurred by you, your spouse or other eligible dependents, for which you request reimbursement under the Employers Medical Reimbursement Plan. You must provide hospital or doctor bills or other evidence that the expenses were incurred. Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. Then date and sign the form. **Send this form along with your supporting documentation to: MedBen, Specialty Services Unit, 1975 Tamarack Rd., P.O. Box 1096, Newark, OH 43058-1096.**

	Expense # 1	Expense # 2	Expense # 3	Expense # 4	EXAMPLE
Date Service Was Actually Provided					10-7-99
Name of Person Receiving Medical Service/Relation to You	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Jane Doe <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Type of Service					Eyeglasses
Total Expense	\$	\$	\$	\$	\$ 100.00
Amount Reimbursed Previously, or Paid/Payable under Another Plan	\$	\$	\$	\$	\$ 0.00
Reimbursement Requested	\$	\$	\$	\$	\$ 100.00

Total Reimbursement Requested \$ _____

To the best of my knowledge and belief, my statement in this Reimbursement Request Form is complete and true. I certify that I or my family member has received the services described above on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Employers Plan or any other Health plan, FSA plan or HRA plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is for prescription drugs, I certify that such drugs are not prescribed for cosmetic purposes. I understand that these expenses may not be used to claim any Federal income tax deduction or credit.

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).

Employee's Signature

Date

Examples of expenses for which you may be able to receive reimbursement include:

- Medical and Dental expenses not covered under any other plan
- Deductibles and co-payments that you are responsible for under your primary medical or dental plan, or under any other medical or dental plan
- Prescription drug co-payments, over the counter antacids, cold medications, pain relievers, allergy medications
- Eye exams, eyeglasses, contact lenses, and other vision expenses
- Orthodontic expenses
- Hearing exams, hearing aids, other hearing expenses
- Physical therapy (not massage therapy)
- Payment to a treatment center for alcoholism
- Chiropractics
- Acupuncture
- Psychotherapy

Examples of expenses for which you cannot be reimbursed include:

- Custodial care
- Health Insurance premiums that you or your spouse pays for coverage under another health plan
- Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods
- Medical expenses of an individual who has been certified as chronically ill (e.g., eligible for long-term care benefits)
- Health club dues
- Social activities, such as dance lessons
- Bottled water
- Maternity clothes
- Diaper service or diapers
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins taken for general health purposes
- Uniforms
- Cosmetic surgery or other similar procedure, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevents or treats illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Transportation expenses to and from work, even though a physical condition may require special means of transportation
- Household or domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework)

Required supporting documentation:

- A bill or receipt (**including date of service, name of patient, provider name-address, amount, and type of service**) from a doctor, dentist, pharmacy or other supplier;
- Explanation of benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by the medical/dental/vision plan(s) under which the employee or any eligible dependents are covered;
- Store receipts are acceptable **ONLY** for hearing aid batteries, contact solution and over the counter medications. The receipt **MUST HAVE** the following information printed on the receipt: **Store name, date of purchase, Product name and amount of product.**

Employees may not submit proof of payment in the form of a cancelled check or credit/debit card receipt unless it is accompanied by the other required documentation.