CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES

1. Instructions (incomplete claim forms will not be processed)

– Please see the full list of instructions on the following page.

2. Employer / Employee Information ❍ **New Address? Check the box if the address listed below is new**

Employer Name _____

Employee Name _____ **SSN** _____

Street Address _____

City / State / Zip Code _____ **Daytime Phone** _____

3. List of Eligible Expenses
(over-the-counter medicines and drugs are now ineligible unless accompanied by a prescription or letter of medical necessity from your provider)

Family Member	Relationship to Employee	Date of Service	Description of Expenses	Amount Requested
JANE	SPOUSE	1.1.11	PRESCRIPTION	$15.00
> Enter the total amount requested for reimbursement and attach receipts before sending				

4. Employee Authorization

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my FSA plan and that these expenses have been incurred during the plan year. Furthermore, I declare that I am requesting payment only for expenses that have not and will not be paid under any other benefit plan or program and that I am solely responsible for the accuracy of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my FSA plan.

Employee Signature _____ **Date** _____

5. Employee Release if Emailing Claims

According to the regulations as set forth by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have established the appropriate administrative, technical, and physical safeguards to prevent Protected Health Information (PHI) from intentionally or unintentionally being used or disclosed in violation of HIPAA's requirements. The safeguards EBS has put in place include sending your supporting receipts, EOBs and claim forms through our secure fax or through US mail.

If you choose to send us your documentation containing PHI through email (custserv@ebsbenefits.com), you understand that such email is not secured and you are responsible for securing your information in an appropriate manner. Any transmission of your PHI through email may result in unauthorized disclosure of your PHI and, consequently, an exposure risk to you or your dependents. By sending us your claims via email and by signing the below, you understand that EBS is not responsible for any information transmitted by you or your agent on your behalf.

Employee Signature _____ **Date** _____

CLAIM FORM FOR MEDICAL / DEPENDENT CARE EXPENSES ~ *INSTRUCTIONS*

- Complete the Employee / Employer Information requested under Section 2.
- Fully complete all fields in Section 3. **Claim forms with incomplete information will be rejected.** Please list each receipt and itemize each expense. Additional pages may be attached. Receipts with a description of service(s) rendered or an Explanation of Benefits from your insurance provider are required for reimbursement. Credit card receipts or cashed checks are not acceptable documentation.
- Under Section 4, read the Employee Authorization carefully and sign noting your agreement.
- **Keep complete copies of all receipts and forms submitted to EBS for audit purposes.** EBS is not responsible for providing copies to participants.
- Completed claim forms should be faxed or mailed to the following address:
  EBS, P.O. Box 11657, Pleasanton, CA 94588 **Fax: 925.460.3929 (preferred)**
- Be sure to include your employer's name on the form.
- Be sure to note if there has been an address change. There is a circle to check on the claim form to indicate that the address listed is new.
- Attach all receipts to the claim form before sending to EBS. Receipts MUST include the following information:
  - Name of the patient (you, your spouse or dependent) unless expense is an OTC purchase;
  - The date the service was provided or the date the item was purchased;
  - The name of the service provider or the merchant;
  - Description of the service or item purchased;
  - A prescription or letter of medical necessity from your health provider if it is an OTC drug or medicine purchase;
  - The amount/cost of the item or service provided.
- All over-the-counter (OTC) expenses must be accompanied by proper documentation from your health provider. The receipt for OTC expenses must include a description of the product, the date of the purchase, the name of the service provider (drugstore, doctor, etc.) and the amount of the item(s). Effective January 1, 2011, all OTC drug and medicine expenses must be accompanied by a prescription or letter of medical necessity from your provider to be eligible under your FSA plan.
- Be sure all expenses were incurred during the plan year or period of active plan participation before submitting your claim.
- Verify that your expenses were not previously submitted or paid through your Benny card.
- If your claim is rejected, you will be notified in writing explaining the reason and requesting the necessary information needed to process your claim.

Top two reasons claims are denied

- Cancelled checks and credit card receipts are provided as proof of an incurred expense / purchase.
- The statement from the provider lists only payments made (does not list a description of the services rendered or does not list the dates of the services / purchases).

Per the IRS, receipts are required that show both a description of services / purchases and the date of the services / purchases.