brms

HEALTHCARE FSA

REIMBURSEMENT CLAIM FORM

EMPLOYEE INFORMATION

Employer: _____ SSN or ID #: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number(s) Mobile: _____ Other: _____

Email: _____

HEALTHCARE FSA CLAIM INFORMATION

Claim	Name of Member	Relation to Employee	Date(s) of Service	Provider	Description	Amount Paid by You
1						
2						
3						
4						
5						
6						
Total Healthcare FSA Claims Reimbursement						

Review the second page of this claim form for reminders pertaining to filing a Healthcare FSA Claim with BRMS, eligible expenses and appropriate documentation.

I certify that the expenses for which reimbursement is requested under my Employer's Healthcare FSA Plan were incurred by myself or my eligible dependents, and that these expenses were incurred within the plan year period of my election. I also certify that the incurred expenses have not been reimbursed, and that I will not seek reimbursement, under any other plan covering health benefits. The expenses are for medical care, excluding cosmetic purposes. I will not use expenses reimbursed through my Employer's Healthcare FSA Plan as deductions when filing my income tax return. I authorize Benefit & Risk Management Services (BRMS) to issue the amount requested above from my Employer's Cafeteria Plan account in accordance with the terms and provisions of the Plan.

Employee Signature: _____ Date: _____

FORM SUBMISSION & QUESTIONS

PHONE: (888) 326-2555

SECURE FAX: (866) 410-0880

MAIL: BRMS-Flex
PO Box 1697
Folsom, CA 95763

HEALTHCARE FSA

General FAQ's

EXAMPLES OF ELIGIBLE HEALTHCARE FSA EXPENSES

Eligible Healthcare FSA expenses are determined by the IRS. Knowing exactly what you can use your Healthcare FSA funds for will save you time and effort in the long run. You can reference IRS Publication 502 for more information on eligible expenses; however, some examples include:

- Out-Of-Pocket expenses: co-pays, coinsurance, or deductible for health, prescription, dental, or vision plans
- Everyday medical expenses: sunscreen, band-aids, and contact lens solution
- Health condition that requires the purchase of prescription medications on an ongoing basis
- Glasses and contacts
- Orthodontia care not covered by insurance is an *exception.*
    - We cannot accept a claim for the entire contracted amount. We will accept claims for the initial down payment usually associated with the appliances.
    - Monthly payments will also be accepted as the charge for the medical services rendered for that month.
    - If the entire orthodontia process is not complete in one visit, we can only reimburse you for the cost per adjustment visit until the entire process is complete. Please do not send Visa or MC receipts.
    - A copy of the orthodontist contract must be submitted for first time orthodontia claims.
    - Contact BRMS Customer Support at (888) 326-2555 to discuss the details of this potential expense and its requirements

REMINDERS WHEN SUBMITTING HEALTHCARE FSA CLAIM FORM

- Sign your claim form.
- Enclose appropriate documentation *with* claim form (See "Documentation Samples" below)
- If expense is covered by insurance, submit to appropriate carrier prior to submitting claim to BRMS. An Explanation of Benefits (E.O.B.) will be necessary to verify appropriate financial responsibility and reimbursement amounts. Attach an E.O.B. from the insurance carrier.
- Verify that documentation contains the date and description of service, the amount, and the provider's name stamped on receipt.
- BRMS may request further information, if necessary, to process your claim according to IRS guidelines.

DOCUMENTATION/SUBSTANTIATION SAMPLES

<u>Acceptable documentation may include the following:</u>

- Itemized Statement or bill from your provider, which includes:
    - Provider Name
    - Patient Name
    - Type of Service
    - Costs
    - Date of Service/Purchase (the date of service, not the date of payment, must fall within the plan year for which you are currently enrolled)
- Explanation of Benefits (E.O.B.) from insurance carrier
- Pharmacy Statement which includes:
    - Provider Name
    - Patient Name
    - Name of Drug
    - RX number
    - Costs

<u>Unacceptable documentation may include the following:</u>

- Canceled checks
- Credit/cash receipts with no descriptions
- Balance forward statements