



Mail completed form to:

Meritain Health
P.O. Box 30111
Lansing, MI 48909

Fax to:
Customer Service:

1.888.837.3725
1.800.566.9305, option 5

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Employer Name: _____

Employee Name: _____ SS# or ID#: _____

Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____ Is this a change of address? Y or N

Flexible Spending Account (FSA)

| Date of Service | Name of Provider | Type of Service | Name of Patient | Amount of Expense | Was this service covered by any insurance plan? |
|---------------------------------------|------------------|-----------------|-----------------|-------------------|---|
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| | | | | \$ | Y / N |
| Total amount requested from your FSA: | | | | \$ | |

Please fill out all requested information completely. For further instructions, see Guidelines for Reimbursement on the back of this form. If more space is needed, list additional requests on a separate page. Please include all requests in the total. A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature: _____ Date: _____

Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, and sign and date the form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

Health Flexible Spending Account

- Attach a copy of the Explanation of Benefits (EOB) for each submission. All claims **MUST** be submitted to your insurance company prior to request for reimbursement. **Estimates for services that have not yet been incurred cannot be accepted.**
OR
Submit a paid receipt for your copays. **Credit card receipts, canceled checks, or cash register receipts cannot be accepted for copays. Itemized cash register receipts are acceptable for over-the-counter (OTC) items/supplies.**
OR
If you do not have insurance coverage, submit an itemized statement from the provider showing the provider's name and address, patient name, date of service and description of service and amount charged. Additionally, prescription expenses must include the drug name or number. **Balance forward or paid on account statements cannot be accepted.**
- Orthodontic reimbursement: For the first request, submit a copy of the Service Agreement or contract itemizing the treatment period, down payment, monthly payment, banding date and amount covered by insurance, if any. For subsequent claims, submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement.

Health Care Expenses Generally Eligible for Reimbursement

You *Should* Claim

- Fees for health services or supplies provided by physicians, surgeons, dentists, ophthalmologists, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, or Christian Science practitioners.
- Acupuncture.
- Fees for hospital, ambulance, laboratory, surgical, obstetrical, diagnostic, dental and X-ray services.
- Costs incurred, including room and board, during treatment for alcohol or drug addiction at a hospital or treatment center.
- Special equipment, such as wheelchairs, special handicapped automotive controls, and special phone equipment for the deaf.
- Special items, such as dentures, contact lenses, eyeglasses, hearing aids, crutches, artificial limbs and guide dogs for the vision or hearing impaired.
- Transportation for needed medical therapy.
- Nursing services.
- Rehabilitation expenses.

You *Should NOT* Claim

- Any items which will be paid for by insurance or for which you are reimbursed by insurance or any other health plan.
- Bottled water.
- Health club dues.
- Any illegal operation or treatment.
- Programs to control weight (unless the program is undertaken at a physician's direction to treat an existing illness, including obesity).
- Elective cosmetic surgery.
- Medical insurance premiums paid outside of your company by you or your spouse at his or her place of employment.
- Nursing care for a normal, healthy baby.
- Maternity clothes.
- Burial expenses.