Health Care Flexible Spending Account Claim Form

PLEASE PRINT

Name _____ Social Security #_____

Address_____ Employer_____

_____ Daytime Phone _____

☐ Please check box for change of address

Instructions for requesting reimbursement

- Complete this form, making sure that you sign and date below.
- Attach supporting documentation.
  - --- **Eligible expenses covered by medical/dental plans** must be submitted to all other plans under which the expense is eligible. Then request reimbursement of deductibles, co-payments, and co-insurance by submitting this form along with a copy of the Explanation of Benefits (EOB) form that shows the patient name, nature and amount of expense, date incurred, and certification of the amount of expense that is your responsibility.
  - --- **Eligible expenses NOT covered by medical/dental plans** may be submitted directly by completing this form and attaching supporting documentation. Documentation must show patient name, nature and amount of expense, date incurred, and provider of service (see back of form for examples of unacceptable documentation).
  - --- **Documentation will not be returned; therefore, it is recommended that you keep copies of your submissions.**

Payments will be made directly to you; they cannot be assigned to the provider of services.

Date expense was incurred	Amount to be Reimbursed	Name of Service Provider	Brief description of expense	Patient Name
Total				

I request payment of $_____ from my Health Care Reimbursement Account for the above expenses. To the best of my knowledge, these expenses are eligible under the plan (see reverse side) and they are for myself or for an eligible dependent. I further certify that these expenses have not been reimbursed under my major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan, and that I will not seek reimbursement under any such plan. I understand that any expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

Signature_____ Date_____

Attach supporting documentation and return to:

Mail to: **LD&B Benefits Administrators**
205-C South Liberty Street
Harrisonburg, VA 22801

Fax to: **(866) 292-8331 / (540) 438-4133**
Phone support: **(540) 437-1425**, **(877) 532-5478** M – F 8:00 – 5:00 EST
Secure upload at: **www.LDBbenefitsadmin.com**

Health Care Expenses

Expenses incurred by you, your spouse, or your dependents (if you provide more than half of their support) that are not reimbursable from another source (i.e. insurance) *and that are incurred while you are an active participant in the plan* may be eligible for reimbursement. In general, eligible expenses are amounts paid for the diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Also, transportation expenses primarily for and essential to medical care may be eligible expenses. Expenditures that are merely beneficial to the general health of the individual are not eligible.

ELIGIBLE EXPENSES:

- Medical and dental expenses that are covered but not paid by insurance (deductibles, co-pays, co-insurance) **excluding cosmetic procedures**.
- Vision and hearing expenses including examinations, eyeglasses, contact lenses and solution, hearing aids, and seeing-eye dogs
- Fees paid to medical doctors, chiropractors, and hospitals
- Dental care including orthodontia
- Routine physical examinations, x-rays, and lab fees
- Prescription drugs, including insulin and birth control pills
- Special equipment (wheelchairs, crutches, etc.) bought or rented (Letter of medical necessity may be required.)
- Ambulance service and other transportation costs necessary to receive medical care
- Weight loss prescriptions/programs to treat a diagnosed medical condition (Documentation must include a letter of medical necessity from your physician.)
- Diagnostic procedures (such as body scans, pregnancy kits, ovulation monitors, and blood pressure/cholesterol/bone density checks through health fairs)
- Breast pump and supplies

INELIGIBLE EXPENSES:

- Any cosmetic procedures or other items (dental bleaching, electrolysis, porcelain veneers, etc.)
- Vitamins or nutritional supplements
- Marriage counseling
- Electric toothbrush
- Weight loss prescriptions/programs for your general health
- Vision warranties

Please note - Examples of unacceptable documentation are as follows:

- Cash register receipts for prescription medications
- Credit card receipts or statements
- Cancelled checks
- Balance forward or balance due statements
- Payment on account receipts

Expenses must be incurred during the period of coverage for which you made your election while you are an active participant. Expenses are considered to be incurred on the date services are provided – not when the service or item is billed or paid for. Any balance in your account after the claim submission cut-off date for a plan year will be forfeited.

Expenses reimbursed from this plan are not eligible for the medical care tax deduction. For more detailed information, see IRS Publication 502, "Medical and Dental Expenses," available from your local IRS office. Please note that this publication is written specifically for income tax purposes, and while it is a useful tool in determining eligible expenses, there are slight differences between what can be claimed on your income taxes and what can be reimbursed from your flexible spending account.