# MEDICAL FLEXIBLE SPENDING ACCOUNT
## ACCOUNT RULES AND CLAIM FILING INSTRUCTIONS

***RULES***

- You can only submit a claim if you are participating in the Cafeteria Plan.
- You can only be reimbursed for eligible expenses incurred during the coverage period in which your contributions are made.
- You can submit a claim at any time during the plan year, and for a specified period after the plan year, as described in the Summary Plan Description. If you terminate employment, the services must have been incurred prior to your date of coverage termination.
- IRS rules stipulate that any money left in your account(s) after all reimbursements for the plan year have been processed cannot be carried forward or returned. Money in one account cannot be used for expenses incurred in another account. *For example, any unused funds in the Dependent Care FSA cannot be used to reimburse medical expenses.*
- You cannot submit a claim for a service period that begins in one plan year and ends in the next plan year. You must file two reimbursement claims, one for each plan year covering the period during that plan year.
- You cannot receive payment from any other source for expenses reimbursed by claim, and you certify that you are not eligible to bill any other source for the reimbursed expenses. Additionally, If you have received reimbursement for expenses, you cannot claim the expenses for income tax purposes.

***INSTRUCTIONS***

- Complete ALL information on the form for each amount claimed for reimbursement. Incomplete forms cannot be processed (this includes for lack of SSN).
- Attached copies of required documentation to the claim (See Required Documentation below for information).
- Sign and date the claim.
- Make a photocopy of the claim for your records.
- Submit the claim and required documentation via fax, email, mail or through our website. *Please limit faxed claims to 9 pages or less.*

***REQUIRED DOCUMENTATION***

- ✓ Medical procedures (including doctor visits, labs, surgery, etc.) and Dental procedures: Please submit an itemized statement or an Explanation of Benefits (EOB) from the insurance carrier that reflects the date of service, services rendered, total cost of procedure, total insurance coverage and total patient responsibility. An EOB is required for any expense other than a co-pay. If the expense is not covered by insurance, you may submit an itemized statement that includes name of the patient and provider, date of service, type of service/supply, and charge. *Balance forward, previous balance, credit card receipts, canceled checks or account statements are not sufficient documentation.*
- ✓ Prescriptions: Submit a copy of the pharmacy Rx label or receipt which includes the service date, patient name, name of prescription, and amount.
- ✓ Over-the-Counter Items: Submit a copy of the cash register receipt which includes the place and date of purchase, items purchased and cost of purchase. If items listed on receipt are not obvious for identification purposes, please handwrite a detailed description or include a copy of the container the item came in.
- ✓ Orthodontia: Approximately one-third of the total cost can be reimbursed up front, as it can be attributed to the molds, application of appliances, etc. Afterward, reimbursements will be released monthly throughout the duration of the treatment plan as services are incurred. In order to be reimbursed for orthodontic expenses, you must provide a copy of the orthodontic contract, along with an EOB if insurance is covering any portion of the treatment.
- ✓ Massage Therapy, Supplements, Vitamins or expenses not covered by insurance but may be required for a specific medical/dental condition: Submit a letter from your physician stating a specific condition has been diagnosed and that this service or supply is medically necessary for the treatment of that condition.

P.O. Box 520, Euless, TX 76039 Phone: (817) 731-6258
Fax: (817) 731-9029 Email: claims@abybenefits.com Website: www.abybenefits.com

# MEDICAL FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

NAME_____ EMPLOYER_____ SSN _____-_____-_____

HOME (MAILING) ADDRESS_____ CITY_____ STATE_____ ZIP_____

☐ *check here if your address has recently changed*

EMAIL ADDRESS _____@_____ DAY PHONE (_____) _____-_____ (optional)

**For HRA & FSA Combination Claims ONLY:** Was the amount applied to your deductible? Yes No
Was the amount you paid for co-insurance? Yes No

**Is your proof of expense attached?** Yes No

| SUMMARY OF EXPENSES | | | | Dates of Service | | Payment |
|---|---|---|---|---|---|---|
| Name of Individual Receiving Services | Relationship to Employee | Name of Service Provider | Nature of Expense | From MM/DD/YY | To MM/DD/YY | Employee Responsibility (check box if debit card used) |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| ❖ **An EOB is required for any expenses other than a co-pay. Claims must be filled out completely and received by 12pm prior to the processing day in order to obtain reimbursement during the next processing cycle.** | | | | | **TOTAL** | |

I (above named Participant) understand and agree that:

- These expenses are not reimbursable from any other health plan, insurance or other source, and will not be used to claim any federal income tax deduction or credit.
- The Unreimbursed Medical expenses listed above would be deductible medical expenses under Internal Revenue Code Section 213 and are allowed under Prop. Treas. Reg. 1.125-2;
- If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent under the plan as defined in Code Section 152;
- By submitting this information (via fax, e-mail, or any other media), I am responsible for any inappropriate use or disclosure that may occur due to incorrect or inaccurate transmissions;
- I authorize the Plan and its service provider, their respective agents, employees, sub-contractors and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan Administration purposes such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation;
- I authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud;
- I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above; and
- This authorization does not in any way limit any right that ER/PSP, their respective agents, employees, sub-contractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

EMPLOYEE SIGNATURE: _____ DATE: _____