



ALT BENEFIT CONSULTANTS, INC.

ACCOUNT RULES AND CLAIM FILING INSTRUCTIONS FOR FLEXIBLE SPENDING ACCOUNTS MEDICAL

Rules for Flexible Spending Account (FSA) Medical Accounts

- You cannot submit a claim unless you are participating in the Cafeteria Plan.
- You can be reimbursed only 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 can not be used for expenses incurred in another account. For instance, any unused amounts left in the medical account can not be used to reimburse dependent care expenses.
- 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.
- If you have received reimbursement for expenses, you cannot claim the expenses for income tax purposes.
- You cannot bill for a service period that begins in one plan year and ends in the next plan year. File two reimbursement claims, one for each plan year covering the period during that plan year.

Instructions for FSA Medical Accounts

1. Complete ALL the information on the claim form for each amount claimed for reimbursement. Incomplete forms will be returned, this includes lack of social security number.
2. Attach copies of required documentation to the claim. *Please see “Required Documentation” below for information on what documentation is required for reimbursement.
3. Sign and date the claim.
4. Make a photocopy of the claim for your records.
5. Submit the Claim with attached receipts via fax 9 pages or less at (817) 731-9029 or mail to 6410 Southwest Blvd. Suite 204, Fort Worth, TX 76109.

Required Documentation for FSA Medical Accounts

- ✓ Medical procedures (including doctor visits, labs, surgery, etc.) and Dental procedures - please submit an Explanation of Benefits (EOB) from the insurance company or an itemized statement. EOB's are required for expenses other than co-pays. Itemized statements and EOB's will need to reflect the date of service, services rendered, total cost of procedure, total insurance coverage and total patient responsibility. If the expense is not covered by insurance, you may submit an itemized statement. Itemized statements must include 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 - please submit a copy of the pharmacy script (Rx label) or receipt which includes the service date, patient name, name of drug, and amount.
- ✓ Over-the-counter items – please submit a copy of the cash register receipt which includes the place of purchase, date of purchase, items purchased and cost of purchase. If items listed on receipt are not obvious for identification purposes, please include a copy of the container the item came in.
- ✓ Orthodontics - orthodontics can only be reimbursed as services are incurred. Approximately one third of the total cost can be reimbursed up front, as it can be attributed to the molds, application of appliances, etc. After that, reimbursement can be made in monthly payments, 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 explanation of benefits from the insurance company (if insurance is covering any portion of the orthodontics).
- ✓ Massage therapy / supplements / vitamins / or expenses that are not covered by your insurance but may be required for a specific medical/dental condition - please submit a letter from your physician stating a specific medical condition has been diagnosed, and that this service or supply is medically necessary for the treatment of that medical condition.



Alt Benefit Consultants

Simplify

6410 Southwest Blvd., Suite 204 Fort Worth, TX 76109 www.altbenefits.com

(817) 731-6258-Phone (817) 731-9029-Fax

FLEXIBLE SPENDING ACCOUNT MEDICAL REIMBURSEMENT REQUEST FORM

EMPLOYER _____ NAME _____ SOCIAL SECURITY# _____ - _____ - _____

HOME (MAILING) ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

check here if your address has recently changed.

1) Do you have coverage for medical expenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	HMO <input type="checkbox"/>	5) Is your proof of expense attached?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2) Do you have coverage for dental expenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	DMO <input type="checkbox"/>	<u>For HRA Claims ONLY:</u>	
3) Is any portion of the service covered by your insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>		6) Was the amount applied to your deductible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4) Is your EOB (Explanation of Benefits) attached? (if applicable)	Yes <input type="checkbox"/> No <input type="checkbox"/>		7) Was the amount you paid for co-insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>

SUMMARY OF EXPENSES				Dates the service incurred		Payment
Name of person receiving services	Relationship to Employee	Provider of services	Nature of Expense	From MM/DD/YY	To MM/DD/YY	Amount \$\$ (check box if myrsc card used)
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
❖ EOB's are required for expenses other than co-pays. 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 _____