



P. O. Box 4346, Missoula, MT 59806

# HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT REQUEST

To send scanned claims, or for additional forms, go to:

[www.allegianceflexadvantage.com](http://www.allegianceflexadvantage.com)

FAX: 406-523-3149 or, toll-free 877-424-3539    PHONE: 406-721-2222 or, toll-free 877-424-3570

Please print legibly in black or blue ink. Do not include day care expenses on this form.  
Do not use a highlighter on this form.

|  |  |
|--|--|
| Employer Name: _____   | Total # of Pages Submitted: _____                            |
| Employee Name: _____   | Please call to confirm receipt? Yes <input type="checkbox"/> |
| Employee ID: _____<br>(Social Security Number or, if assigned, alternate ID) | Return Phone Number: _____-_____-_____                       |
| Comments : _____   | Attention: _____   |

**PLEASE SEE REVERSE FOR CLAIM FILING INSTRUCTIONS.** List eligible medical, dental or vision services and expenses for you and your family. Only list the amount of the expense you have to pay **after insurance** pays its share. Insurance premiums are not eligible.

| <u>TYPE OF EXPENSE</u>  | <u>SERVICE DATES</u>                        | <u>AMOUNT REQUESTED</u> |
|---|---|-------------------------|
| Medical Reimbursement Requested ***   | From _____ To _____                         | \$ _____                |
| Prescription Reimbursement Requested  | From _____ To _____                         | \$ _____                |
| Vision Reimbursement Requested  | From _____ To _____                         | \$ _____                |
| Dental Reimbursement Requested  | From _____ To _____                         | \$ _____                |
| Orthodontia Reimbursement Requested<br>(Ortho contract available on website.) | From _____ To _____                         | \$ _____                |
|   | <b><u>TOTAL REIMBURSEMENT REQUESTED</u></b> | <b>\$ _____</b>         |

Include independent, third-party documentation of your expenses with this claim form. If any of these expenses were covered by insurance, attach a copy of the explanation of benefits (EOB) from your insurance company. For expenses that are not eligible for submission to insurance, send a copy of a bill or invoice identifying the service, service date, and total charges. If required documentation is not attached, your reimbursement may be delayed.

I certify that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my tax dependents, and/or spouse (if filing federal taxes jointly). These expenses have not previously been reimbursed under any plan and I will not seek reimbursement under any other health plan. I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed through my health FSA may not be claimed on my individual tax return.

Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

Check here if your address has changed. New address: \_\_\_\_\_  
\_\_\_\_\_

\*\*\* As of 01/01/2011, over-the-counter purchases are not reimbursable unless recommended in writing by a medical professional to treat a medical condition.

## **FILING A CLAIM**

Please read these important reminders for quick and efficient reimbursement:

- Please make sure to fill out your form completely (employer, ID#, your name). Documentation must include service dates, service description and charges for services received.
- Combine all like reimbursement requests. For example, If you are submitting several prescription receipts for reimbursement, enter the range of dates over which the purchases were made and the total of all the receipts on the prescription line:

**Prescription Reimbursement Request    From: 7/1/09    To: 7/31/09    \$145.78**

- Service dates must be within the plan year to be eligible expenses. If your employment terminates during the plan year, service dates must be within the plan year **and** while you were an active participant in the plan (ie: eligible and making contributions).
- If the service is eligible for insurance, an explanation of benefits must accompany the claim form, unless the bill from the provider shows the amount that insurance has paid, or the receipt is clearly a co-pay amount. **Bills from providers that estimate insurance payment will not be reimbursed.**
- If the reimbursement requested is not eligible for submission to insurance for reimbursement consideration, a bill or receipt showing date, service and charges is adequate documentation of the expense, as long as there is no reference to insurance coverage on the bill or receipt.

Eligible claims received must total at least \$15.00 before a check will be mailed or an electronic deposit initiated by Allegiance.

Save time! Direct deposit is a convenient and easy way to receive your flex reimbursement- see [www.allegianceflexadvantage.com](http://www.allegianceflexadvantage.com) and sign up today!