



**Benetech**

benefits • payroll • hr

P.O. Box 348 | One Dodge Street  
North Greenbush, NY 12198  
(518) 283-8500 | 800-698-4753  
Fax (518) 283-2384 | [www.benetechadvantage.com](http://www.benetechadvantage.com)

# Flexible Spending Account Medical Expense Recovery Form

See reverse for instructions regarding this form.

Go Green – File a claim online! Log in at [www.benetechadvantage.com](http://www.benetechadvantage.com).

Your Employer's Name \_\_\_\_\_

Your Name \_\_\_\_\_ Your ID# \_\_\_\_\_

Your Email \_\_\_\_\_

When submitting this form you must complete the information requested (all fields required) and attach an **Itemized Receipt or an Explanation of Benefits** from your insurance carrier for each expense.

Date(s) of Service	Patient Name & Relationship to Employee <i>(e.g., John Smith – spouse)</i>	Provider Name	Total Reimbursement Requested
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**By signing and submitting this form you acknowledge that all requirements of qualified health care expenses\* per Section 213(d) of the IRS code (as documented in IRS Publication 502), as well as the plan document of your employer, have been satisfied.**

\*If you aren't sure your expense is eligible for reimbursement visit [fsastore.com](http://fsastore.com) and search the Eligibility List.

I hereby certify:

- I will not claim any amounts reimbursed to me under this Plan as a deduction on my personal income tax return.
- I have not/will not be reimbursed for these expenses by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan.
- The service(s) for which I am requesting reimbursement were incurred within the current FSA plan year.
- That the above statements are complete and accurate to the best of my knowledge.
- I understand that reimbursement is not a guarantee that this payment is tax-free.
- I agree to reimburse my employer and/or the administrator of an overpayment which is in excess of the amounts payable under the plan.

Your Signature (required) \_\_\_\_\_ Date \_\_\_\_\_

**Any person who knowingly, and with the intent to injure, defraud or deceive any employer or administrator, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.**

## Medical Expense Recovery Form Instructions

**The form should be completed and signed by the Employee who established the Flexible Spending Account with the Employer listed in the first section on page 1.**

- Enter your name, Employee ID Number (last 4 digits of your Social Security Number), and your email address.
- For each expense the following information is required:
  - List each date of service on a separate line (no date ranges please).
  - List the patient(s) name(s) and relationship(s) to you (the employee). Reimbursement requests for multiple family members may be submitted on the same form. Use separate lines for each patient.
  - List the name(s) of the provider(s). Indicate the grand total requested for reimbursement.
- If you need additional space for extra dates of services, please use an additional form or you may use a spreadsheet. If using a spreadsheet, all required information must be included and that spreadsheet must accompany a signed form. Spreadsheets without an accompanying form will not be accepted.
- Read the certifications carefully to make sure you understand your responsibilities and accountability.
- **The Employee's signature is required**, as indicated by the bold arrow. Please date the form as well in the space provided.

- **Substantiating documentation must accompany the form** (e.g., explanation of benefits (EOBs), itemized receipts, etc.). Itemized receipts need to include:

- Patient name (name of person who incurred the - service or expense) -
- Name and address of the provider or merchant
- Date of service for the amount charged
- Description of service
- Amount due for the service

Receipts for over-the-counter (OTC) items do not need to - include the person's name, but the receipt must display the - name of the item (e.g., bandages). -

**Local Pharmacy**  
12 Main Ave  
Mytown, NY 12345  
(800) 555-1234

★ DATE 08/01/17

★ Patient: **JOHN DOE (518) 555-9876**  
Rx #: 1234567-12345

★ AMOXICILLIN 500MG CAPSULES  
QTY: 90 0 Refill

★ \$8.00

- Submit the form and substantiation to Benetech via:
  - **US mail** -- to the address at the top of the page; or,
  - **Fax** – to 518.283.2384; or,
  - **Email** – to [flexinfo@benetechadvantage.com](mailto:flexinfo@benetechadvantage.com)