INFINISOURCE

Reimbursement Form

Employee name: _____

ID or SSN: _____ Employer: _____

Address: _____

☐ address change

Daytime phone: _____ E-mail: _____

Provide mobile number to receive text confirming receipt of faxed claim _____

Please see reverse side for instructions and documentation requirements. A signed and dated reimbursement form must accompany every claim.

Health FSA/Health Reimbursement Arrangement (HRA)

Submitted claims must include:

- Patient name
- Expense incurred (type of service)
- Amount of expense
- Provider name and address
- Date of incurred expense (date service is provided, not paid)
- Amount insurance paid, if applicable

HRA: Your HRA plan may limit the types of health care expenses that may be reimbursed. Please read your HRA plan's Summary Plan Description (SPD) for eligible expenses.

☐ Process my health care claims under the HRA and the Health FSA benefits.

Date of Service m/d/y to m/d/y		Patient name	Relationship	Account (FSA, HRA)	Service (i.e., medical, dental, vision)	OTC drug name	OTC drug purpose (e.g., allergies)	Amount
						Requested amount		$

☐ Benny Card used for this claim ☐ Use claims to offset a Benny Card transaction claim

Dependent Care FSA

Dependent must be under the age of 13 to be eligible or an adult who is a qualifying relative that is disabled. The expense must happen to allow you and/or spouse to work.

Date of Service m/d/y to m/d/y		Dependent name	Relationship	Age	Provider name	Amount
I certify I provided care as specified.					Requested amount	$
Dependent care provider signature (required when receipt not provided)					Date	

I certify that:

1. The expenses listed have been incurred by me, my spouse or my eligible dependents (as defined by the IRS.
2. All applicable insurance or other medical plan benefits have been exhausted.
3. Listed OTC expenses are to treat a medical condition.
4. I will not deduct these reimbursements as a tax credit on my federal income tax return. I have not been reimbursed for and will not see reimbursement of, the listed expenses under any other plan covering such expenses.
5. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.
6. I have received the taxpayer ID number of my dependent care provider. I understand that I must provide this information on my federal income tax return.
7. All services for which reimbursement or payment is claims by submission of this form were provided during a period while the undersigned was covered under the company's FSA and/or HRA with respect to such expenses.
8. To the best of my knowledge, all statements on this form are true, correct and complete.

_____

Employee signature (You must sign this form to be reimbursed.)

Infinisource has incorporated the HIPAA Privacy requirements to reflect our business practice regarding your insurance coverage.

15 E. Washington St. • PO Box 488 • Coldwater, MI 49036-0488 • 866-370-3040 • Fax: 800-379-5670 • E-mail: fsa@infinisource.com

Reimbursement instructions and documentation requirements

Please read the instructions before completing this form.

1. Complete all required information.
2. You must sign and date the form.
3. You must attach required documentation.
4. Keep copies of the form and documentation for your tax records.
5. Mail to Infinisource, PO Box 488, Coldwater, MI 49036 or fax to 800-379-5670.

The IRS does not allow check copies, charge slips or balance statements as acceptable documentation. See #3 below for orthodontia requirements. You may combine family members on one form. You must submit separate reimbursement forms for different plan years.

Documentation requirements for Health Care expense reimbursement

1. **Medical or dental expenses** If processed by your medical plan, please submit the expenses to the medical plan administrator or insurance carrier first. Then submit this form and an Explanation of Benefits containing all the supporting documentation. Proof of expense payment is not required.
2. If you do not have medical plan coverage for dental or vision expenses, submit an itemized statement from the provider showing the patient name, provider name and address, date of service, description of service and amount charged. For reimbursement of contact lens solutions and cleaners, submit a cash register receipt describing the item. If the receipt does not describe the item, provide a copy of the package indicating price and product name.
3. **Orthodontia**
   a. If your plan prohibits advance payment for orthodontia expense, submit a copy of the Truth in Lending Statement, orthodontia contract or financial agreement with your initial submission itemizing the treatment period, down payment, monthly payment amount and the amount covered by insurance, if any. If this is a recurring expense, please indicate and payment will be automatically made on a monthly basis. Submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement for ongoing treatment.
   NOTE: the plan can reimburse orthodontia expenses paid in advance. The payment date determines plan year. Additional fees such as x-rays, molds, etc., are reimbursable when incurred. The banding fee (attaching brackets/bands on teeth) can be paid in full when incurred. Down payments are reimbursed after being paid and banding has taken place. Please submit an itemized receipt showing down payment.
   b. If your plan allows advance payment for orthodontia expenses, please submit a copy showing payment for orthodontia.
4. **Prescriptions** Submit a copy of the receipt showing patient name, drug name, date prescription was filled and co-payment amount charged. Cash register prescription receipts or charge slips showing the prescription and amount charged cannot be accepted, as the patient name and drug name or number are required.
5. **OTC expenses** You must indicate the drug name and its purpose to treat the patient. All OTC drug claims must be accompanied by an itemized receipt. Cash register receipts must include provider name and address, purchase date, OTC expense name (if the drug/medicine name is not on the cash register receipt, submit the package portion with the drug/medicine name and price with the cash register receipt). NOTE: some OTC drugs are not eligible for reimbursement unless a specific medical condition exists. Ineligible drug reimbursement requests (cosmetic reasons [Rogaine], weight loss, general health [vitamins]) must include a physician recommendation for the purchase and list a medical condition.
   Effective January 1, 2011, OTC medicines or drugs are not eligible for reimbursed under Health Flexible Spending Accounts (FSA) or HRAs without a doctor's prescription.

Documentation requirements for Dependent Care reimbursement

1. Complete FSA Reimbursement Form, have provider sign and date and submit to Infinisource, or
2. Complete FSA Reimbursement Form and attach documentation which must include provider name and address, dependent name, service dates and expense amount. A cancelled check is insufficient documentation.

IMPORTANT

- Claims must be fully incurred before reimbursement. Infinisource cannot process claims for future dates of service except as indicated above.
- Some expenses associated with dependent care are not eligible (overnight camp, food and transportation costs). If you are submitting charges for a day camp, documentation must show that it is a day camp.
- Your must provide the IRS with the name, address and tax ID or Social Security Number of the dependent care provider on your federal income tax return. If you are unable to provide this information, the IRS may deny the exclusion for the dependent care spending account.

Claims appeal

If your claim is denied in whole or in part, you may appeal by requesting review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time as described in the denial notice in which to request a second review by the plan administrator. You will be notified in writing of the review decision as soon as reasonably possible, but no later than 60 days after the review request is received. Your SPD outlines this in more detail.

Claim confirmation

You can view your claim status anytime at www.infinisource.com (click login and then select FSA or HRA Participant). If you mail your claim, do not fax it. Fax claims to 800-379-5670 and keep the confirmation for your records. Allow two business days before checking the website or calling for the status of faxed claims.