

Limited-Purpose Flexible Spending Account Health Care Claim Form

(Please See Instructions on Reverse Side)

Employee Information (Please Print)

For address changes, please contact your employer's HR/benefits department.

Last Name: _____ First Name: _____ Middle Initial: _____

Subscriber ID Number: _____ Group Number: _____

Home Address: _____

Phone Number: _____ Email Address: _____

Employer's Name: _____

Limited-Purpose Flexible Spending Account (Only available with high-deductible health plan options)

The LPFSA provides tax-exempt funds you can use to pay for eligible dental and vision expenses that aren't covered, or are partially covered, by your medical, dental or vision insurance plans.

Please print — Use one line for each receipt — Don't combine two or more receipts on one line —
Use additional forms if necessary.

Date of Service	Name of Person Receiving Service	Name of Provider of Service	Description of Service/Supply	Requested Reimbursement Amount
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$

Date of Service	Name of Person Receiving Service	Name of Provider of Service	Description of Service/Supply	Requested Reimbursement Amount
				\$
				\$
				\$
				\$
				\$
Total Reimbursement Requested				\$

Employee Information

I certify that:

- › I am requesting reimbursement for all eligible expenses listed above that were received by myself or an eligible dependent.
- › I've received the expenses listed above and am seeking reimbursement from the Flexible Spending Account.
- › These expenses occurred within my period of coverage during the plan year.
- › These expenses haven't previously been reimbursed and will not be presented for reimbursement through any other health plan.
- › I understand that I alone am fully responsible for the accuracy of all information I've provided by submission of this claim form.
- › I agree to submit and keep documentation for any expenses I requested reimbursement for, as may be required by the IRS.

Please check the box below and type your first and last name and the date in the space provided:

I acknowledge that I am signing this claim form electronically. I consent to conducting this transaction electronically, and I acknowledge that my electronic signature is the legal equivalent of my handwritten signature.

Employee Signature: _____ Date: ____/____/____

If you don't want to submit this claim form electronically, please print, sign and return this form and supporting documentation by:

Fax to:
1-888-666-1221

Email to:
HDHP_Claims@bcbst.com

Mail to:
BCBST Claims Service Center
1 Cameron Hill Circle STE 0022
Chattanooga, TN 37402-022

Questions:
Member Service
1-800-565-9140
bcbst.com

LPFSA Claim Reimbursement Instructions

LPFSA Health Care Expenses Include:

- › Dental plan deductibles and expenses your plan doesn't cover.
- › Other qualified dental expenses your plan doesn't cover.
- › Vision care expenses, including qualified expenses, your plan doesn't cover.
- › Expenses solely for cosmetic reasons or for general health and well-being aren't usually eligible expenses for medical care.

Supporting Documentation

Supporting third-party documentation for health care expenses must include at least one of the following:

Explanation of Benefits (EOB)

- › The statement you receive each time a claim is submitted to your health, dental or vision plan.

Itemized statement or receipt containing

- › Type of service or product provided.
- › Date the expense was incurred.
- › Name of the employee/dependent who received the service/product.
- › Person/organization providing the service/product.
- › Amount of the expense after insurance benefits were provided (if applicable).

Ineligible Expenses and Documentation

The following aren't allowable under Code Section 125 of the IRS:

Ineligible Documentation

- › Credit card receipts or canceled checks.
- › Billing statements showing "Previous Balance," "Balance Forward," or "Received on Account."

Ineligible Expenses

- › Amount paid by insurance.

Before Submitting This Form Please:

- › Complete the claim form in full.
- › Sign and date the claim form.
- › Include the appropriate documentation.
- › If multiple items are listed on a receipt, **CIRCLE** the items filed for reimbursement. **DO NOT highlight the items.**
- › Make sure supporting documentation equals the total amount you're claiming for reimbursement.
- › Keep a copy of your claim form and any original receipts for your records.

