

**Benefit Advantage**

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# Pages: \_\_\_\_\_

Company Name: \_\_\_\_\_

**Health Care FSA CLAIM FORM**

|                 |        |       |           |            |
|-----------------|--------|-------|-----------|------------|
| <b>NAME:</b>    | Last   | First | MI        | SS#        |
| <b>ADDRESS:</b> | Street | City  | State ZIP | PHONE: ( ) |

 Please check if this is a new address

| MUST FILL OUT      |                  | MEDICAL EXPENSE CLAIMS      |                         |                   |                        |
|--------------------|------------------|-----------------------------|-------------------------|-------------------|------------------------|
| Patient Name       | Relationship     | Date of Service<br>MM/DD/YY | Name of Provider        | Claim Amount      | Description of Service |
| SAMPLE<br>John Doe | SAMPLE<br>Spouse | SAMPLE<br>01/01/03          | SAMPLE<br>Prevea Clinic | SAMPLE<br>\$10.00 | SAMPLE<br>Office Visit |
|                    |                  |                             |                         |                   |                        |
|                    |                  |                             |                         |                   |                        |
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|                    |                  |                             |                         |                   |                        |
|                    |                  |                             |                         |                   |                        |
| <b>Total:</b>      |                  |                             |                         |                   |                        |

There is a \$25 minimum payment amount.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of \$10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the \$10.00 fee.

You must attach documentation that includes the following information for your claim to be paid:

- Date(s) of Service Performed
- Description of Service Performed \*(i.e. eye exam, co-pay)
- Amount of expense incurred
- Name of Patient, & Service Provider

\*Undefined codes are not acceptable descriptions of your expense.

**EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT**

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this Flexible Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

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

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Original receipts will not be returned**, please keep a copy for your own records.You may review your account at [www.benefitadvantage.com](http://www.benefitadvantage.com) for balance details.