Healthcare Flexible Spending Account Reimbursement Form

How to file a claim:

Online: The fastest way to receive reimbursement for your completed claim is through the web or MyChoice Mobile App. Reimbursement for completed claims submitted via web or mobile app is processed within 2 – 3 business days.

Via email, mail or fax: Fill out your form electronically and submit via email, fax, or mail. Completed claims submitted via email, mail or fax may take up to 7 – 10 business days to process.

- **Email**: claims@mychoiceaccounts.com
- **Mail**: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax**: 855-883-8542

Instructions for filling out this form:

This form is available for only the Healthcare Flexible Spending Account and cannot be used for expenses incurred with a Health Savings Account. For more information on how to submit a Health Savings Account reimbursement request, please visit us at www.businessolver.com/mychoice-accounts/participants/health-savings-account.

Complete each section completely. If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

- **A** SERVICE TYPE *(indicate the type of expense that is being claimed for reimbursement)*
- **B** START AND END DATE OF CLAIM
- **C** AMOUNT SUBMITTED FOR CLAIM

SECTION 1: YOUR INFORMATION

MEMBER SOCIAL SECURITY NO. or EMPLOYEE ID *(Required, No Dashes)*: 1 2 3 4 5 6 7 8 9

COMPANY NAME: ACME COMPANY

MEMBER LAST NAME *(Required)*: S M I T H

MEMBER ZIP CODE *(Required)*: 9 0 0 1 2

MEMBER EMAIL: SSMITH@ACME.ORG

MEMBER DATE OF BIRTH (MM/DD/YYYY) *(Required)*: 1 2 0 4 1 9 9 0

MEMBER TELEPHONE NUMBER: 4 9 0 1 0 5 5 6 8 7

SECTION 2: YOUR EXPENSES

A SERVICE TYPE: ■ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION ☐ OTHER

PATIENT NAME: SUSAN SMITH

B SERVICE START DATE (MM/DD/YY): 0 2 0 1 2 2

SERVICE END DATE (MM/DD/YY): 0 2 2 1 2 2

C AMOUNT: $ 3 2 3 . 1 9

Submitting a completed claim:

To ensure your claim is complete, and can be processed as quickly as possible, provide all information as required in Your Information section, and all necessary information as required for a claim being submitted for your eligible dependent(s). **If any of the required documentation or information is missing, your claim will not be complete and may be delayed in processing.**

Below are 5 pieces of information which must be included in the documentation submitted with your claim:

1. Name of the member (or eligible dependent) whom incurred the expense
2. Date the expense was incurred (not the date paid)
3. Name of service provider or carrier name
4. Description of the service and/or expense
5. Amount of the expense

If you have questions on what expenses are eligible for reimbursement under the Healthcare Flexible Spending Account, please reference IRS Publication 502.

Please note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.

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SECTION 1: YOUR INFORMATION

◯ MEMBER SOCIAL SECURITY NO. or ◯ EMPLOYEE ID *(Required, No Dashes)*

COMPANY NAME

MEMBER LAST NAME *(Required)*

MEMBER ZIP CODE *(Required)*

MEMBER EMAIL

MEMBER DATE OF BIRTH (MM/DD/YYYY) *(Required)*

MEMBER TELEPHONE NUMBER

SECTION 2: YOUR EXPENSES

SERVICE TYPE

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ PRESCRIPTION ☐ OTHER ________

PATIENT NAME ________

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$ ____.__

SERVICE TYPE

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ PRESCRIPTION ☐ OTHER ________

PATIENT NAME ________

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$ ____.__

SERVICE TYPE

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ PRESCRIPTION ☐ OTHER ________

PATIENT NAME ________

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$ ____.__

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.

I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.

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