

INTEGRATED BENEFITS - FLEX/HRA REIMBURSEMENT FORM

EMPLOYER: _____ EMPLOYEE NAME: _____
 SSN #: _____ Phone #: _____ Email: _____
 (Please Check Box If Address Has Changed) HOME ADDRESS: _____

FLEXIBLE SPENDING ACCOUNT/HEALTH REIMBURSEMENT ARRANGEMENT

CLAIM ATTACHMENTS – Failure to follow these guidelines will result in reimbursement delay or possible denial.

FSA Requirements:

*An ***“Itemized Statement”*** from the provider **MUST** be submitted showing:

- Provider’s Name/Address
- Patient’s Name
- “Actual”*** Date of Service when the Service was Provided
- Description of Service & the Amount Charged

* An ***Explanation of Benefit (EOB)*** from your Medical Insurance Carrier

NOTE: *The Above Two (2) Forms of Documentation **ARE** the **ONLY** Forms of Documentation that **ARE** Acceptable under IRS Guidelines.

- ***Balance forward or paid on account statements CANNOT be accepted.***
- ***Credit card receipts, cancelled checks, or cash register receipts CANNOT be accepted for services.***
- ***Itemized cash register receipts are Only acceptable for over-the-counter medications***

HRA Requirements:

*A Copy of the ***Explanation of Benefits (EOB)*** from your Medical Insurance Carrier **MUST** be submitted.

- Estimates for services that have not yet been incurred CANNOT be accepted.***

(Please Check Method of Payment)

Date of Service	Name of Provider (e.g. Physician, Hospital, Dentist, Pharmacy, Insurance Carrier, etc.)	Type of Service (e.g. Copay, Rx, Ortho, Insurance Premium, etc.)	Patient Name	Amount of Expense	Paid w/ Flex Debit Card	NOT Paid w/ Flex Debit Card	Recur- ring Expense
				\$			
				\$			
				\$			
				\$			
				\$			

Total amount requested from your ***FSA/Cafeteria Plan***: \$ _____ (Manual Amounts Only– Paid for Service Other Than with your FSA Debit Card)

And/Or

HRA: \$ _____ (Be Sure to Submit Your Explanation of Benefit)

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

(Please Check One)

Name of Day Care Provider	Dates of Service		Dependent’s Name	Amount of Expense	Paid with Flex Debit Card	Paid Manually
	From	To				
				\$		
				\$		
				\$		

Daycare Provider’s SSN# or Tax ID#: _____

I certify that I have actually incurred these eligible expenses. I understand that expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse’s income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee’s Signature

Date

Mail to: IBA, Claims Department, 10588 W. Business Park Lane, Idaho 83709**. Fax to: 208-287-0311. Email to: claims@myconsumerplan.com

For claim inquiries call Toll Free (877) 287-0310 or local (208) 287-0310

****Make copies for yourself, as these documents will not be returned. If you Fax or Email your claim, Keep the Original.**

INTEGRATED BENEFITS ADMINISTRATION

Recurring Claims Instructions

We believe in simplicity. That's why we'd like to make filing your Flexible Spending Account (FSA) claims as easy as possible with our recurring claims options. A recurring claim allows you the freedom to submit your claim only once, but continue receiving reimbursements throughout the plan year. You may set up your Dependent Care, Individual Health Premium, Parking, and Orthodontic claims on a recurring status.

To get your claim set up as a recurring status, select the option that reads on the **FlexHRA Claim Form "Please Check One"** if your claim is a recurring claim and attach a copy of your contract." Below is the information required for each type of recurring claim.

Dependent Care: Submit a completed **FlexHRA Claim Form** and an **Integrated Benefits Administration Dependent Care Contract**. Both of these forms can be found on our website at www.myconsumerplan.com under the "**Downloadable Forms**" navigation link. **You'll need to submit a new contract each plan year.** Dependent Care claims can only be paid with funds that are currently available in your FSA at the time of the claim. The balance of the claim will continue to release as you contribute more funds to your account.

Individual Health Premium: Submit a completed **FlexHRA Claim Form** and a **Copy of the Schedule/Declaration Page** from your insurance company. Claim forms can be found on our website at www.myconsumerplan.com under the "**Downloadable Forms**" navigation link. Your Schedule/Declaration Page should show that your insurance is billed to your home address, include the valid dates of coverage, and dollar amount paid. **You'll need to submit a new Schedule/Declaration Page each plan year.** Individual Health Premium claims can only be paid with funds that are currently available in your FSA at the time of the claim. The balance of the claim will continue to release as you contribute more funds to your account.

Parking: Submit a completed **FlexHRA Claim Form**. Because you can't typically provide documentation or a contract for parking services, your signed claim form is sufficient. By signing the claim form, you are verifying that the information is accurate should you be audited by the IRS.

Orthodontic: Submit a completed **FlexHRA Claim Form** and a **Copy of your Orthodontic Contract**. The contract needs to show the charges, description of services, dates of service (can be a date range), and name of the patient. **You'll need to submit a new contract each plan year.** Your claim form and contract can be sent to us via email, fax, or mail. Our contact information is provided below. Once we receive your claim form and contract, we'll automatically generate a payment each pay period without any more effort on your part. For fastest payment, we recommend signing up for direct deposit should your employer offer this option. Signing up is easy. Visit www.myconsumerplan.com under the "**Downloadable Forms**" navigation link and click on the **Direct Deposit Form**.

All Other Claim Submission Instructions

Please refer to the **FlexHRA Claim Form** under the **Claim Attachments** section that lists **Both the FSA & HRA Documentation Requirements** that are "**Acceptable**" under the **IRS Guidelines**. Please follow these guidelines in order not to delay or possibly deny your claim submissions.

Please be clear with your claim submissions-

- Make sure that your "Itemized" Statement or Explanation of Benefit (EOB) shows the Amounts Applied/Billed are the same that you list on your **FlexHRA Claim Form**. Meaning your "Itemized" Statement or EOB should match what you list on your **FlexHRA Claim Form**. Varying amounts applied/billed **ONLY** slows down your claim reimbursement/submission.
- You can **ONLY** submit claims that have been **INCURRED within your Current Plan Year**. Claims incurred outside of your Plan Year **ARE NOT** eligible for reimbursement.
- Be sure to "**Check**" the appropriate boxes letting us know if you used your **Flex FSA Debit Card** to cover your expense or if you **Paid Manually**. If you Paid Manually; please be sure to list the amount you are requesting on your **FlexHRA Claim Form**.