# FSA/HRA REIMBURSEMENT CLAIM FORM *(Please Print Clearly)*



***Want your reimbursement faster? File your claim online via the employee portal (www.BRiWeb.com) or via the BRiMobile app, if allowed by your plan.***

| **PART 1** | **PART 2** ☐ *Check here if address has changed and provide new information below.* |
|---|---|
| **Employee Name:** | **Street or PO Box:** |
| **Member ID:** | **City:** |
| **Employer:** | **State:** **Zip Code:** |

**PART 3**

| **Provider & Service Rendered/Item Purchased** | ***Pay from Prior PY?** | **Date(s) of Service** | ****First & Last Name of Person Receiving Service (HRA Only)** | ****Relationship (HRA Only)** | ****Date of Birth (HRA Only)** | **Amount** | ***For Office Use Only*** |
|---|---|---|---|---|---|---|---|
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | ☐ YES | | | | | | |
| | | | | | TOTAL = | 0.00 | |

**Submit claim by:**

**Fax: (585) 427-9320**

**or**

**Mail: ATTN: Claims Department**
**Benefit Resource, Inc.**
**245 Kenneth Drive**
**Rochester NY 14623-4277**

BRi Benefit Resource, Inc.

Sign Here

***Signature Required:*** _____ ***Date:*** _____

**Employee Certification:** By signing the above, I request reimbursement for Medical and/or Dependent Care expenses listed above. Enclosed are itemized bills, receipts or EOBs verifying these expenses. Each expense listed is for a service/item provided to me or a qualifying individual, has not been purchased with a Beniversal® Prepaid Mastercard®, and will not be reimbursed from any other source. Medical expenses were incurred only for an immediate medical purpose. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and cannot be claimed as deductions on my personal income tax.

***If your plan offers the extended grace period allowed by IRS regulations, you must check Yes if you wish to have this expense reimbursed from the prior plan year.***

****Effective for plan years that begin on or after January 1, 2017, reimbursement of eligible expenses from your HRA can only be for you, your spouse and/or your eligible dependents who are covered under a group health insurance plan as outlined in your Plan Highlights. For example:***

- ***if your HRA plan year begins January 1, 2017 and your Plan Highlights indicate that expenses must be provided to you, your spouse or eligible dependents who are covered by a group health insurance plan, then you can be reimbursed only for eligible services provided on/after January 1, 2017 for qualifying individuals.***
- ***if your HRA plan year begins June 1, 2017 and your Plan Highlights indicate that expenses must be provided to you, your spouse or eligible dependents who are covered by a group health insurance plan, then you can be reimbursed only for eligible services provided on/after January 1, 2017 for qualifying individuals.***

***The following information is required:***

***Relationship: Complete this column using Self, Spouse or Dependent.***
***Qualifying individual's date of birth.***

***See page 2 for important information on completing and submitting this form.***

## INSTRUCTIONS FOR COMPLETING YOUR CLAIM:

1. Part 1 of the claim form *must* be completed in full.
2. Part 2 of the claim form should only be completed if your address has changed.
3. Part 3 of the claim form ***must*** be completed in full.
4. For each item you are claiming in Part 3, you must attach a copy of itemized bills, statements, receipts or insurance company Explanation of Benefits (EOBs). This documentation from your provider *must* include the following information *(please retain originals for your personal records)*.
   • Name of provider • Your out-of-pocket cost for the service • Type of service provided • Date(s) service was provided • Name of person receiving the service
   Credit or debit card information should not be included.
5. IRS regulations require additional documentation for the following:
   • Effective 01/01/2011, over-the-counter drugs and medicines require a prescription.
   • Dual purpose items require a Certification of Medical Necessity form (*can be obtained from the Benefit Resource website)*.
6. The claim form ***must*** be signed and dated after reading the Employee Certification.
7. Submit the completed claim form and all related documentation to:

**Fax: (585) 427-9320 or ATTN: Claims Department**
**Benefit Resource, Inc.**
**245 Kenneth Drive**
**Rochester NY 14623-4277**

## CLAIM SUBMISSION REMINDERS:

- Credit card statements, cancelled checks and balance forward/prior balance statements *are not* acceptable.
- The service being claimed must be provided to you or a qualifying individual within the time frame indicated in your Plan Highlights.
- In general, IRS regulations do not require that you pay for a service before requesting reimbursement. A request for reimbursement must be based on the date when the service was provided, not the date when a payment was made. (The IRS allows one exception: orthodontia expenses can be based on date of payment, date of service or payment due date on statements/coupons.)
- Claims must be submitted *after* a service is provided, but *before* the end of the run-out period following the end of your plan year.
- Claims must be received by Benefit Resource, Inc. within the time frames specified in the Plan Highlights.
- An expense paid with the Beniversal Card or that has been reimbursed from any other source cannot be submitted for reimbursement.
- Items on a claim form or supporting documentation should never be highlighted since highlighted items can be hard to read. Credit or debit card information should not be included.

## SOME EXPENSES THAT ARE ***NOT*** ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT INCLUDE:

- Personal care items (e.g. shampoo, soap, electric toothbrush, toothpaste, mouthwash)
- Teeth whitening
- Insurance premiums

## SOME EXPENSES ARE ***ONLY*** ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT IF CERTIFIED BY A LICENSED MEDICAL PROVIDER AS PREVENTING, TREATING, OR MITIGATING A SPECIFIC PHYSICAL DEFECT OR ILLNESS:

- Cosmetic services
- Vitamins
- Non-prescription sunglasses
- Exercise and weight loss programs





Phone: (800) 473-9595
Website: www.BenefitResource.com