



**Blue Cross Blue Shield  
of Wyoming**

An Independent Licensee of the Blue Cross  
and Blue Shield Association

**REQUEST FOR  
REIMBURSEMENT  
Flexible Spending Accounts  
Health Reimbursement  
Arrangements**

**FlexShare Benefits**  
PO Box 2266 4000 House Avenue  
Cheyenne, WY 82003  
307.432.2788 1.888.557.2230  
Fax: 307.632.1654  
Email: [fsb@bcbswy.com](mailto:fsb@bcbswy.com)  
[www.wyomingblue.com](http://www.wyomingblue.com)

**EMPLOYEE INFORMATION**

**If Change of Address, Please Mark Box**

Name		Social Security Number			Employer		
Home Address		City	State	Zip	Phone	Email	

**REIMBURSEMENT INFORMATION**

No.	Provider of Service	Date(s) of Service	Acct Code *	Dependent/Spouse (if applicable)		Amt. Req.	Office Use Only	
				Name	Relation		Amt. Denied	Claim Type Code
1								
2								
3								
4								
5								
6								
<b>TOTALS</b>								

\*Account Codes: M - MBD FSA Medical Flexible Spending Account  
D - DEPFSA Dependent Care Reimbursement Account  
H - HRA Health Reimbursement Arrangement

\*\*Daycare Provider Signature/Date

\*\*Daycare Provider Tax ID# or SS#  
MUST HAVE Federal Tax ID # or SS # on dependent day care claims

**\*\*\*INCOMPLETE FORMS WILL BE RETURNED\*\*\***

**\*\*\*\*\*PLEASE SUBMIT EXPLANATION OF BENEFITS (EOB) BACK AND FRONT REQUIRED\*\*\*\*\***

**INSTRUCTIONS**

1. Read the guidelines for eligible reimbursements on the reverse side of this form before submitting a request for reimbursement.
2. Complete the above sections, giving all applicable information on you, your spouse, or dependents and the expenses to be reimbursed.
3. Attach the Notification of Benefits received from your insurance carrier. If the service is not covered by your insurance, attach an itemized bill, receipt, or other verification of the expense showing the service(s) provided, date(s) for charges, and dependent/spouse name(s), if applicable.
4. Sign and date below and send the original, scanned copy, or fax of this Request for Reimbursement form, with attachments, to:

**FlexShare Benefits**  
A Division of Blue Cross Blue Shield of Wyoming  
4000 House Avenue \*\*\* P. O. Box 2266 \* Cheyenne, WY 82003  
Toll-Free 1.888.557.2230 Fax 1-307-632-1654 Email [fsb@bcbswy.com](mailto:fsb@bcbswy.com)  
[www.wyomingblue.com](http://www.wyomingblue.com) go to **MEMBER**-click on **FLEXSHARE BENEFITS** for all your needs

**EMPLOYEE CERTIFICATION**

The undersigned participant in the Plan(s) certifies that all expenses for which reimbursement or payment is claimed, by submission of this form, were incurred during the period while the undersigned was covered under the Company's Flexible Spending Plan or Health Reimbursement Arrangement with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage or other plan.

The undersigned confirms any Dependent Care Reimbursement has not been reimbursed or is not reimbursable under any other Dependent Care Assistance Plan coverage and if reimbursed from this Dependent Care Assistance Program, such amount will not be claimed as a tax credit.

The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan(s), the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan(s) which relate to such expense.

Our Health Reimbursement Arrangement (HRA) Plan may be limited to the types of health care expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan, for a list of eligible expenses.

**IN ORDER FOR REIMBURSEMENT THE FORM MUST BE SIGNED!!**

Employee's Signature

Date

## GUIDELINES FOR ELIGIBLE REIMBURSEMENTS

### GENERAL:

- ◆ If you apply for reimbursement of expenses that the IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply, according to the Internal Revenue Code. Similar treatment will be applied to overpayment of reimbursed expenses or reimbursement for expenses that have already been reimbursed from some other source.
- ◆ In general, Section 125 of the Internal Revenue Code governs the tax status of Flexible (or Cafeteria) Benefit Plans, of which Employee Flexible Spending Accounts are a part. Eligibility for pre-tax reimbursement is covered specifically in Code Sections 105 and 106 (Accident/Health Plans), and Section 129 (Dependent Care). Health Reimbursement Arrangements are outlined in Section 105 of the Internal Revenue Code. Related medical expenses allowed through an FSA or HRA are defined in IRC 213.

### MEDICAL SPENDING ACCOUNT (Type Code - M):

- ◆ Eligible expenses are qualified medical/dental/vision expenses of the employee, spouse, and dependent(s) that are not eligible for reimbursement from any other source. Submit to your insurance prior to Flex. Expenses that are eligible for reimbursement under a health insurance plan should not be included on this form.
- ◆ A list of typical IRS-approved medical/dental expenses is available from your Personnel Department.
- ◆ Over the counter drugs and medicines will require a prescription effective January 1, 2011.

### DEPENDENT CARE SPENDING ACCOUNT (Type Code - D):

- ◆ Expenses to provide care for your eligible dependents may qualify for reimbursement. Eligible dependents include children under the age of 13, a disabled child, a disabled spouse, or a dependent disabled parent.
- ◆ Provide Daycare Tax Identification number or Social Security number. Must be included with every request or your claim will be returned.
- ◆ To be eligible, you must be working while your dependents receive care. Also, if you are married, your spouse must be:
  - ◆ A wage earner, or
  - ◆ A full-time student for at least five months during the year, or
  - ◆ Disabled and unable to provide for his or her own care.
- ◆ Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:
  - ◆ Licensed nursery schools and daycare centers.
  - ◆ Individuals -- other than your dependents -- who provide care for your children in or outside your home, or for your disabled spouse or dependent parent in your home.
  - ◆ Housekeepers, maids, or cooks in your home, to include their food and lodging in your home, as long as their services are performed for the benefit of your eligible dependent(s).
- ◆ IRS Regulations limit the amount of reimbursement expense for dependent care to the lower of the annual earned income of your or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns \$250 per month (one dependent) or \$500 per month (two or more dependents).
- ◆ Under IRS Regulations, qualified individuals can receive a tax credit for dependent care costs. This credit is claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Spending Account.

### HEALTH REIMBURSEMENT ARRANGEMENT (HRA) (TYPE CODE H):

- ◆ Your employer has identified certain qualified medical expenses that may be reimbursed through your HRA.
- ◆ Your Health Reimbursement Arrangement (HRA) Plan may be limited to the types of health care expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan, for a list of eligible expenses.