Instructions

1. Employee must complete Account Holder Information.

2. Complete this **Request for Reimbursement Form** in its entirety. Please ensure your supporting documentation clearly indicates the requested amount. If you have been previously partially paid on a claim and are resubmitting for the remainder of the payment, please indicate the amount of the payment expected.

3. Check the appropriate box in the **Supporting Documentation** section and submit Acceptable Supporting Documentation as described below. (When attaching small receipts, we suggest you tape them to a standard size sheet of paper.) Send copies of supporting documentation along with this form. Keep original receipts and other documents for your records.

   a) For office visits – An Explanation of Benefits (EOB) statement from your insurance carrier, OR an itemized receipt or bill from the provider that includes the provider's name, patient's name, a description of the service, the original date of the service*, and your portion of the charge.
   b) For prescription drug purchases – A pharmacy statement or receipt from your pharmacy including the patient's name, the Rx number, the name of the drug, the date the prescription was filled, and the amount.
   c) For over-the-counter (OTC) medicines – A written OTC prescription along with an itemized cash register receipt that includes the merchant name, name of the OTC medicine or drug, purchase date, and amount, OR a printed pharmacy statement or receipt from a pharmacy that includes the patient's name, the Rx number, the date the prescription was filled, and the amount.
   d) For over-the-counter health care-related products – An itemized cash register receipt with the merchant name, name of the item/product, date, and amount.
   e) For qualified insurance policies, and insurance premium billing notice (e.g., itemized bill including name of insurance provider, name of patient/insured, amount charged, coverage dates, etc.) ***and*** proof of payment (e.g., copy of front and back of check, credit card confirmation, etc.)

   Please Note: Credit card receipts, canceled checks, and balance forward statements do not meet the requirements for acceptable documentation, unless used for insurance premium claims.

4. Sign and date **Account Holder Certification**.

5. **Submit reimbursement form and copies of supporting documentation to CONEXIS Flexible Benefits Services**:

   CONEXIS Flexible Benefits Services
   Fax: 888-866-3312 Phone: 866-279-8385
   P.O. Box 227197
   Dallas, TX 75222

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

*The date of service, not the date of payment, must fall within the plan year for which you enrolled and while you are a participant in the plan.

Employee Information

Employer Name _____

Account Holder Name _____ Account Number / SSN _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ ZIP Code _____

Add your email address to know when we processed this claim:

_____

Claim Information

Patient Name	Date of Service	Type of Service	Requested Amount
			$
			$
			$
			$
			$
Total Amount Requested (continue on additional page if necessary)*			$ 0

Supporting Documentation

Attach Supporting Documentation (*see list of acceptable documentation above)

☐ I have attached copies of Explanation of Benefits (EOBs) for deductible and coinsurance requests.

☐ I have attached itemized bills for expenses not covered by medical, dental, or vision insurance.

☐ I have attached an insurance premium billing notice for qualified insurance policies ***and*** proof of payment.

Account Holder Certification

- I certify the expenses listed for reimbursement are eligible health care expenses under the Internal Revenue Code and my employer's HRA Plan ("Plan");
- I certify insurance coverage was in force for the periods of coverage listed above;
- I certify the services listed above have been received by me, my spouse, or my eligible dependent(s) on the dates indicated;
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person;
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit;
- I understand that I may be required to provide further details about some expenses, including a statement from a medical practitioner that the expense is for a specific medical condition;
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount. I further understand failure to repay the Plan could result in adverse income tax consequences;
- By providing my email address, I authorize CONEXIS to send account information to me via email.

_____ _____

Account Holder Signature Date

Medical expenses which have been reimbursed under this plan are not deductible for income tax purposes.

*Only the total amount supported by the attached documentation (receipts) will be paid.

Fax: 888-866-3312 Phone: 866-279-8385