

Check here if address has changed.



PART 1. EMPLOYEE INFORMATION (Please Print)

Name (Last, First, Middle Initial)		Date of Birth (mm/dd/yyyy)	SS # or Member ID
Address (Street, City, State, Zip)			
Email	Phone	Employer Name	

PART 2. HEALTH CARE EXPENSES

DESCRIPTION OF EXPENSE AND REIMBURSEMENT AMOUNT REQUEST. Please Place Each Expense on a Separate Line.

Patient Name	Dates of Service		Description of Service	Provider of Service	Reimbursement Amount Requested
	From	To			
Total Reimbursement:				\$	

PART 3. EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses requested from my reimbursement account were incurred by me (and/or my eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement. I will not use the expenses reimbursed as deductions or credits when filing my income tax return.

Any person who knowingly and with intent to injure, defraud, deceive, or files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature

Date

Reimbursement Request Form Employee Instructions

Please read these instructions before completing the Reimbursement Request form.

Step 1	Complete all areas of Part 1: <i>Employee Information</i> .
Step 2	<p>Complete all areas of Part 2: <i>Health Care Expenses</i>. Please enter each expense on a separate line. Attach any supporting documentation to this form. The IRS requires that an Explanation of Benefits, or an itemized statement, be provided in order to substantiate your expense request.</p> <ol style="list-style-type: none"> 1. Name of person receiving the services, and their relationship to the account holder. 2. Date the service was provided <ul style="list-style-type: none"> • The medical service must be incurred during the plan year. (Claims for future dates of service(s) incurred prior to the plan year are not eligible for reimbursement). 3. Description of service <ul style="list-style-type: none"> • The description of the service(s) must be provided. The description may be as generic as “co-pay” or “office visit.” • Drug name and prescription # (if applicable). 4. Merchant name or facility provided the services. 5. Total out of pocket expense for the service(s). <p>Ineligible receipts include: credit card slips, bank statements, cancelled checks, and generic receipts.</p> <p>Eligible documentation needed for reimbursement:</p> <p>Receipt must include: a) the name of the provider or merchant, b) the date of purchase, c) description of the product, d) amount of the expense, and e) a copy of the label or packaging of product.</p> <p>Documentation must include: a) name of person who incurred the service, b) date of service, c) description of service, d) merchant name or facility providing the service(s), and e) total out of pocket expense for the service.</p> <p>Preferred documentation includes an <i>Explanation of Benefits</i> or an <i>itemized statement</i> from the provider, with all necessary information.</p>
Step 3	Read Part 3: <i>Employee’s Certification for Reimbursement</i> . Sign, and date the form where indicated.
Step 4	<p>There are four ways to submit your claim(s) to HealthSmart:</p> <ol style="list-style-type: none"> 1) Self Service Portal: https://healthsmart.wealthcareportal.com, and login to the member’s portal site. In order to submit your claim via HealthSmart’s secure portal site, you will need your Member ID or Social Security number. If you do not have your User ID and password, contact Customer Service: 844,516,3658 2) Mobile application: HealthSmart My Flex Spending 3) Fax: 844.319.3669 4) US Mail: P.O. Box 16647, Lubbock, TX 79490-6647