

Health Flexible Spending Account (HFSA) Reimbursement Form



Please mail completed form with itemized statements or receipts and an explanation of benefits form to:
HealthSmart Benefit Solutions ■ P.O. Box 99004 ■ Anchorage, AK 99509-9004
 Toll Free 877.517.6370 or TDD 877.517.6416 ■ Fax: 304.353.8636

Member's Information

| | | | |
|--|------------|----------------------|-----------|
| Name (First, Initial, Last) | | Member ID (required) | |
| Address | | City | State ZIP |
| Daytime Telephone Number (Include Area Code) | Plan Name | Group Number | |
| | AlaskaCare | 5851 | |

Description Of Health Care Expenses (See reverse side for a list of eligible expenses)

| Patient's Name | Relationship to Employee | Date(s) of Service | Type of Service | Expense Amount |
|------------------------|--|--------------------|--|----------------|
| 1. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| 2. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| 3. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| 4. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| 5. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| 6. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| 7. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| 8. | <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | <input type="radio"/> Medical <input type="radio"/> Prescription <input type="radio"/> Vision <input type="radio"/> Dental <input type="radio"/> Orthodontia <input type="radio"/> Other | \$ |
| Total Amount Submitted | | | | \$ |

Certification

I certify that (1) the information I have provided on this form is correct and complete; (2) all expenses for which reimbursement is claimed have been incurred during the period of coverage for myself, my spouse or for an eligible dependent, as defined under my employer's HFSA plan; (3) these expenses have not been reimbursed, and I will not seek reimbursement for these expenses under any other plan covering health benefits; and (4) I will not deduct or claim credit for expenses reimbursed from my HFSA on my federal, state or local income tax returns.

| | |
|--------------------|------|
| Member's Signature | Date |
| | |

Important: You must sign and date this form in order for your claim to be processed.

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Instructions For Filing A Claim

1. Before requesting payment from your HFSA account, you must submit these expenses to your health insurance company.
2. Explanation of Medical Benefits (EOB) provided by your insurance company must be submitted as proof of claim. If this statement is provided, it is not necessary to provide the individual bills or receipts.
3. Your Plan may have a check minimum before your payment will be released. Please call HealthSmart Benefit Solutions at 1.877.517.6370 or TDD 1.877.517.6416 for verification.
4. Please retain a copy of your claim, statements, and receipts for your records.

Eligible Expenses

Eligible health care expenses are for you, your spouse, or your dependents, that have not been and will not be reimbursed by any other medical or dental insurance. Health care includes the prevention, diagnosis, treatment, and care of an illness, injury, disease or physical or mental defect. Examples of eligible expenses are listed below:

- Amounts not paid by medical and dental plans, with the exception of elective cosmetic surgery expenses. For example: deductibles, copayments, and amounts in excess of plan limits.
- The cost of eye and hearing examinations, eyeglasses, contact lenses, and/or hearing aids.

For more information about qualified health care expenses, please refer to IRS Publication 502.

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