BENEFITHELP Solutions®

FSA Healthcare Account
Reimburse Me Claim Form

Fax: 1-888-249-5058
Submit online at www.benefithelpsolutions.com
Ph: 503-412-4254 or 1-877-425-9812
PO Box 67230 • Portland, OR 97268

DO NOT USE A FAX COVER SHEET

ACCOUNT HOLDER INFORMATION

Member ID: _____ **Phone #:** ___ - ___ - ____
Your Social Security Number or your unique ID Number assigned by your program sponsor.

Name: _____
Last First

New Address? YES

Address: _____
Street Apt.

_____ ___ _____
City State Zip

Email Address: _____

Employer Name: N I K E **Group #:** 8 5 0 2

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

1 _____
Name of Dependent / Self

_____
Name of Provider / Merchant

__ / __ / __ Service Date (MM/DD/YY)

$___,___.__ Out-of-Pocket Cost

2 _____
Name of Dependent / Self

_____
Name of Provider / Merchant

__ / __ / __ Service Date (MM/DD/YY)

$___,___.__ Out-of-Pocket Cost

3 _____
Name of Dependent / Self

_____
Name of Provider / Merchant

__ / __ / __ Service Date (MM/DD/YY)

$___,___.__ Out-of-Pocket Cost

MORE EXPENSES? Complete another form.

$___,___.__
TOTAL THIS FORM

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.
To submit healthcare or dental expenses, attach supporting documentation that includes the date of service, name of provider, the service performed and amount of the charge(s). An Explanation of Benefits from your insurance company or an itemized billing statement or receipt from your provider is an acceptable form of documentation. Canceled checks, credit card receipts/statements or balance forward or balance due statements are not IRS acceptable.

I request reimbursement from my Flexible Spending Account for the listed expenses paid or to be paid by me. I certify these expenses are not covered or reimbursable from any other source, nor will I seek reimbursement for these expenses from any other source and that the expense is not for cosmetic purposes. I understand that I cannot use expenses reimbursed through the healthcare account as tax deductions when filing income tax returns. I further certify that the expenses submitted on this claim are for myself and/or my qualified tax dependents as defined under Internal Revenue Code Section 152 (as amended by the Working Families Tax Relief Act of 2004).

Account Holder Signature: _____ Date: _____ Total Number of Pages: _____
Signature of spouse or dependents is not acceptable.