

Participant Information

Completion of all sections in their entirety is required for reimbursement.

Employer Name:	
Employee Name:	Social Security No.:
Street Address: If this is a NEW address please check here. <input type="checkbox"/>	City, State, Zip
Daytime Phone:	Email Address:

Health Care Expenses (Medical, Dental, Hearing, Vision, Etc)

Attach all supporting documentation. See reverse side for instructions.

Flex Card Used	Patient's Name	Patient's Relationship to Employee	Date of Service	Description of Service	Service Provider	Submitted to Insurance? If not, Why?	Amount to be Reimbursed
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
Total							

Dependent Care Expenses (Day Care, Summer Day Camp, Etc.)

Attach all supporting documentation. Provider's Federal Tax ID No. or Social Security No.:

Flex Card Used	Dependent's			Date of Service		Service Provider	Amount to be Reimbursed
	Name	Age	Date of Birth	Beginning	Ending		
<input type="checkbox"/>							
<input type="checkbox"/>							
<input type="checkbox"/>							
Total							

Claim Certification

Signature and date required for reimbursement.

I certify that I (and/or my qualified dependents*) have incurred eligible expenses for which reimbursement is sought under the Flexible Benefit Plan in which I have enrolled and that these expenses have been incurred during the plan year. Additionally, I certify that any over-the-counter expenses for which I seek reimbursement without benefit of a doctor's prescription were incurred in order to treat me or my qualified dependent(s)* for an existing or imminently probable illness and were not purchased for general health or cosmetic purposes. Furthermore, I declare that I am requesting reimbursement for expenses that have not and will not be reimbursed under any other benefit plan or program and that I have not and will not claim these expenses as an income tax deduction. *See reverse for definition of qualified dependents.

Signature:	Date:
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Please submit your completed claim to the following:

INNOVA BENEFIT Services, LLC

Phone: 1-866-276-2411

Fax: 1-877-774-1328 / 1-724-733-4570

questions@innovaben.com

www.innovaben.com

West Coast Regional Office
2025 Gateway Place – Suite 110
San Jose, CA 95110

East Coast Regional Office
795 Pine Valley Drive – Suite 21
Pittsburgh, PA 15239

Instructions

Failure to comply with these instructions may result in your claim being delayed or returned to you.

Fill out all sections of this form. PLEASE TYPE OR PRINT. Once you have completed the form, SIGN and DATE it. Retain copies of all documents for your records. Submit your claim to Innova via mail or fax. Faxing your claim will expedite reimbursement. Contact your employer for reimbursement schedule.

Healthcare Expenses (Medical, Dental, Hearing, Vision, Etc.)

Before requesting reimbursement from your Reimbursement Account, you must **first** submit your expenses to any other benefit plan or program under which you are eligible for benefits. If your expenses are not paid in full or are not covered, you may then request reimbursement from your Healthcare Reimbursement Account.

To be eligible, expenses must be incurred out of medical necessity. Cosmetic procedures or expenses related to general health and well-being are not eligible for reimbursement. **Effective January 1, 2011 a doctor's prescription is required for over-the-counter medicines and drugs.**

Qualified Dependent: In general, a child is a qualifying child if the child is a U.S. Citizen or national or a resident of the U.S., Canada or Mexico and; 1) has the same principal residence of the taxpayer for more than half of the taxable year; 2) has a specified relationship to the taxpayer (such as child, stepchild, fosterchild, sibling or stepsibling or the descendent of one of the above; 3) has not attained the specified age (age 27) at the end of the tax year or is totally and permanently disabled at any time during the year; or 4) did not provide more than one-half of his/her own support during the year. A qualifying relative is someone who is not a qualifying child but meets the relationship, income and support tests of Code Section 152. Please remember, a child must be under age 13 in order to qualify for dependent care assistance.

A. Indicate date of service, type of service (medical,dental, hearing, vision care, etc), service provider, who incurred the expenses and their relationship to you (i.e., self, spouse, or dependent), and the amount to be reimbursed from your Healthcare Reimbursement Account. If you did not submit a claim to your insurance carrier, please explain why in the "Submitted to Insurance" section.

B. SUPPORTING DOCUMENTATION:

1. An Explanation of Benefits from your insurance carrier if the expenses were eligible for reimbursement from any other benefit plan or program but were not paid in full; OR
2. Invoice(s) or receipt(s) indicating ALL of the following:
 - Provider's name and address
 - Date of service
 - Itemized breakdown of services and supplies or name of over-the-counter item. **Effective January 1, 2011 a doctor's prescription is required for over-the-counter medicines and drugs.**
 - Total charges
 - Recipient of services/Patient's name
 - Amount paid by insurance, if any

C. UNACCEPTABLE DOCUMENTATION

- Credit card receipts
- Canceled checks
- Balance forward statements

Examples of Eligible Healthcare Expenses

Acupuncture	Fertility treatments	Podiatrist
Alcoholism or substance abuse treatment	Hearing aids/batteries	Pregnancy tests
Ambulance	Hospital services	Prescriptions and medicines
Artificial limbs or teeth	Insulin	Psychiatric care
Birth control pills	Laboratory fees	Psychologist
Chiropractors	Laser eye surgery	Rehabilitation physical therapy
Christian science practitioner	Learning disability	Speech training
Coinsurance payments	Medical monitoring and testing devices	Sterilization
Contact lenses, cleaners and solutions	Medical services	Smoking cessation program
Crutches	Orthodontia	Vaccines
Deductibles	Osteopath	Viagra
Dental fees (non-cosmetic)	Oxygen equipment	Wheelchair
Eyeglasses and eye exams	Physical exams	X-rays