HUMPHREY & PACE
BENEFIT PLANNING, INC

"The Professional Approach to Insurance"

Flexible Spending Account (FSA)

Request For Reimbursement

PICK UP CHECK ☐ ***(Non-Direct Deposit Only)***
If someone *other than Participant* is to pick up check, list below

_____**(ID Required)**

Unless the PICK UP CHECK box is marked all checks are MAILED.

ADDRESS CHANGE ☐
(If you have had a change of address and do not notify us, and it is necessary to put stop payment on a check that is not received, you will be charged **$15.00**)

Employer _____ Daytime Phone # _____

Employee/Participant Name _____ Last 4 of SS # XXX-XX-_____

Mailing Address _____

City _____ State _____ Zip Code _____

Per IRS Regulations, please attach appropriate documentation that is explained on the reverse of this form.
Please retain copies of the information submitted for your personal tax records. Originals and/or copies of submitted claims will not be returned to you after processing. **You may use one form for multiple expenses.**

	Expense Amounts	Service Date(s)	Brief Description of Services
Health FSA Expenses	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____
	$_____	_____	_____
Dependent Day Care Expenses	$_____	_____	_____
Total Reimbursement Requested	$_____		

EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, my statements in this Request For Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable FSA and/or Dependent Care Plan Year and for eligible participants. I certify that these expenses have not been and are not expected to be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. I have read and understand the information provided on the reverse of this form. I authorize my Account to be reduced by the amount requested.

Employee Signature _____ **Date** _____

700 East Main Street, Ste 107, Medford, OR 97504
Phone (541) 779-5881 **Fax (541) 779-5511** **Email** Claims@hp-benefits.com

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Request for Reimbursement Instructions for FSA and Dependent Day Care Accounts

How to File a Request for Reimbursement

The "Request for Reimbursement" form must be completed and signed for each reimbursement submitted along with IRS Required documentation. You can download the "Request for Reimbursement" form from our website: www.hp-benefits.com .

Please retain copies of the information submitted for your personal tax records. Originals and/or copies of submitted claims will not be returned to you after processing.

Required Documentation for Medical FSA

We must have the following in order to process a request:

- Supporting documentation, which can include, insurance Explanation of Benefits (EOB) or itemized bills/account statements for services you have received.
  Documentation must show the following:
  - **Date of Service(s) (NOT the date paid)**
  - **Provider's Name**
  - **A Brief Description of Service Provided**
  - **Amount responsible by the patient (Funds cannot be reimbursed for expenses that insurance may cover)**

Third party verification is required; therefore, **copies of cancelled checks and/or credit card statements/receipts are not acceptable.**

- In certain instances, statements from your healthcare provider may be necessary to verify the medical necessity of the procedure or prescription. Please call if you have questions.

Required Documentation for OTC Medicines

We must have the following in order to process a request:

- Letter of Medical Necessity completed by a licensed Provider or,
- Supporting documentation from a third party that must include all of the following:
  - **Date of Service(s)**
  - **Provider's Name**
  - **Description of OTC Medicine**
  - **Amount responsible by the patient**
  - **Documentation from a licensed Provider that must include:**
    - **Specific medical condition present** in which item is solely used to treat, dosage/quantity, frequency and duration.

Required Documentation for Dependent Care

We must have the following in order to process a request:

- **Period of Service**
- **Provider's Name**
- **Amount responsible for Period of Service**
- **If your daycare provider does not provide documentation, we will need all the information above, as well as, the Provider's Social Security number or Tax Identification number and their signature verifying documentation is correct.**
- **Childcare expenses may be submitted for children up to the age of 13 and only for care provided while you the employee and your spouse are actively at work .**

Third party verification is required; therefore, **copies of cancelled checks and/or credit card statements/receipts are not acceptable.**

Processing & Payment of Your Request

Humphrey & Pace Benefit Planning, Inc. will process your "Request for Reimbursement" and determine expense, eligibility and fund availability based on your account balances. All eligible expenses must be incurred (i.e. service dates) in your plan year. If you are unsure what your plan year is, please call our office.

- **For Medical FSA** - The maximum reimbursement available to you at any time during your plan year will not be greater than the annual benefit you elected on your enrollment form, less any reimbursements paid to date during the plan year.
- **For Dependent Daycare** - The maximum reimbursement available to you at any time during the plan year will not be more than what has been withheld from your paychecks **AND** sent to the plan administrator, Humphrey & Pace Benefit Planning, Inc.

Your request will be reviewed and determined approved or denied within 2 business days of receipt of the "Request for Reimbursement." Reimbursements are issued to Participants only.

Incomplete Request for Reimbursement Forms or those received without proper documentation attached cannot be processed for approval. If we cannot process your request as submitted, your claim will be sent back to you with an explanation of what is needed in order to process the reimbursement, without exception.

If you have a question or need any assistance, please call our office at (541) 779-5881 or send an email to Claims@hp-benefits.com.

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