Required – You must check one:

☐ **Paid by my Benefits Card** ☐ **Paid Out of Pocket To Be Reimbursed**

*(**DO NOT** combine debit card claims with out of pocket claims. Any forms with combined claims will be returned unpaid)*

REQUEST FOR REIMBURSEMENT

☐ RESUBMIT

MAIL, FAX, or EMAIL completed form to:
BTA - FSA Claims
P.O. Box 530967
Birmingham, AL 35253
Fax: 205-879-2181 **(Do Not Mail if Faxed)**
Email: claims@btai.com

Employer: _____

Employee Name: _____ SSN/EE ID:_____-_____-_____
Last, First MI

Home Address_____
Number/Street City State Zip

Contact Phone: (_____)_____ E-Mail: _____

MEDICAL CARE FLEXIBLE SPENDING ACCOUNT

Supporting documentation must accompany this request form. Each claim must be listed separately. (i.e., one prescription, one doctor's visit per line, etc.)

- Attach a copy of the Explanation of Benefits (EOB) if the original expense was submitted to your Health/Dental/Vision insurance provider.
- If no Explanation of Benefits (EOB), submit a copy of the original **itemized statement showing the five (5) pieces** of information listed below.

Date of Service	For the Benefit of (Name and Relationship)	Description of Service	Provider of Service	Requested Amount
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
(All sections above must be completed for each expense listed or request will be returned.)			TOTAL	

DEPENDENT DAYCARE FLEXIBLE SPENDING ACCOUNT

You must submit a receipt or statement from the provider giving the date range of service, name of eligible individual, name of Provider and amount. You will need to provide the IRS with the name, address and Tax ID or Social Security Number of the dependent care provider on your federal income tax return. If you are unable to provide this information, the IRS may deny the tax exclusion for the dependent care reimbursement account.

Dates of Service MM/DD/YY to MM/DD/YY	Age of Dependent(s) at Time of Service	Dependent(s) Name	Provider of Service	Requested Amount
/ / to / /				
/ / to / /				
/ / to / /				
(All sections above must be completed for each expense listed or request will be returned.)			TOTAL	

I certify, to the best of my knowledge, the expenses listed above are eligible for reimbursement, and I have not previously requested reimbursement for the above expense under this plan or any other plan. I am not eligible to receive additional insurance benefits or reimbursements from any other source for such expenses. I further certify that I am not applying these expenses toward any federal or state income tax deduction or credit. I understand that I must repay my employer any reimbursement amounts that are determined to be ineligible.

_____ _____
Employee Signature Date

We cannot process without your signature and date.
For questions about a claim, or the FSA program, please call 205-879-2824 (Local to Birmingham) or Toll Free 888-714-2824 between 8:00am & 5:00pm CST, Monday through Friday or access your account online at www.btai.com.

Instructions

When To File A Claim

1. Reimbursement of expenses can only be made for eligible medical expenses incurred in the Plan Year, including the Grace Period, if applicable. Only the cost of services already incurred can be reimbursed. For new hires and employees enrolling in the Flexible Spending Account after a Qualifying Change in Status, the eligibility period begins on the date of the qualifying change of status date; for terminating employees, the eligibility period ends on the last day of employment.
2. Submit eligible expenses to your health provider first. After receiving the **Explanation of Benefits (EOB*)** from the provider, submit your EOB* showing your out-of-pocket expenses to BeneTech Administrators, Inc. For a list of eligible expenses, refer to your "Claim Reimbursement Packet" you received at the beginning of the plan year or call us and we can email one to you.
3. You must submit all eligible claims by the end of the plan's run out period. (Ask your Human Resources for details)
4. Be sure to place the corresponding receipts behind the Request for Reimbursement form with which they are listed.

How To File a Claim

Medical

1. The claim may contain medical expenses for several members of the family, as long as they are considered a dependent. For expenses to be eligible, the services must be incurred within the Plan Year.
2. Fill in all fields on the claim form – incomplete forms will be returned for completion. Date and sign the form. Employee's signature is always required, even if the claim is for a dependent, or form will be returned.
3. Attach documentation of your expenses [Explanation of Benefits (EOB*) or if not applicable, itemized receipts] to the claim form as follows:
    a. **Prescribed Drugs:** Receipts for drugs obtained with a written prescription must be on the pharmacy's standard form and must show: (1) patient's name, (2) date purchased, (3) prescription number, (4) name of prescription, (5) amount of charge or co-payment, and (6) name of pharmacy. Or an **EOB*** can be submitted.
    b. **Over-the-Counter Drugs (OTC):** Over the Counter Medications must be accompanied by a doctor's prescription to be reimbursed through your FSA account. Over the counter supplies do not need a doctor's prescription.
    c. **All Other Receipts:** If the expense is covered under your Health Plan, you should submit the **EOB*** you received from your provider showing the: (1) patient's name, (2) date of service, (3) type of service (i.e., office co-pays, x rays, etc.), (4) itemized charge for each service, (5) provider's name and address, and (6) any health plan payment/adjustment for that medical service.
    If the expense is not covered under your health plan or if an **EOB*** is not available, the employee must submit a bill or itemized receipt from the health care provider showing the (1) patient's name, (2) date of service, (3) type of service (i.e., surgery, shots, etc.), (4) itemized charge for each service, (5) provider's name and address, and (6) any health plan payment/adjustment for that medical service.
4. Do not group together different claim amounts and put the total. **Each claim must be listed separately**.
5. When submitting receipts, **do not submit originals** in case you are ever audited by the IRS. Copies of checks or canceled checks and credit card receipts are not considered valid receipts by IRS guidelines. Estimates, Proposals, and Balance Due/Forward statements are not valid receipts as service provider, date of service, & service provided must be on receipt.
    According to the IRS, a valid receipt or bill is one that includes: (1) Date of service, (2) Who the service is provided for, (3) What service was provided, (4) Provider of service, and (5) Amount paid.
6. **Resubmitting** – When notified that the original receipts are not valid, you should resubmit only the valid receipts accompanied by a new Request for Reimbursement form. Check the "RESUBMIT" box at the top of the request form to indicate that this was a previously submitted claim.

***EOB - An "Explanation of Benefits**." This is the form you generally receive each time you, or a health care provider, submit medical, dental or vision insurance claims for payment to your health, dental or vision insurance plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. For expenses that are partially covered by your (or your dependednt's) medical, dental or vision insurance plans, you must submit the EOB with your Request for Reimbursement form.

Daycare

1. The receipt/documentation for daycare expenses must include name and address of provider, provider's taxpayer I.D. or Social Security Number, dates of service, name and age of eligible dependent, and amount paid for the dates of service.
2. Fill in all fields on the claim form – incomplete forms will be returned for completion. Date and sign the form.
3. Employee's signature is always required even if the claim is for a dependent.

*The section titled "Dependent Daycare Flexible Spending Account" on the Request for Reimbursement form is for Daycare only, not medical expenses for dependents.

**Signature of employee must be at bottom of request form, where indicated, with date.

***Mail, Email or Fax your Request for Reimbursement form and receipts to BeneTech Administrators, Inc. Use one method only.

WEBSITE

All manual claims and card swipes, as well as your account balance can be viewed online at **www.btai.com/card.** This link will redirect you our card partner's participant login. Upon your first visit, you will need to create an account by establishing a user ID and a Password. (See Website instructions included)