MAIL CLAIM FORM TO:
McLaren Health Advantage
FSA Unit
PO Box 1511
Flint, MI 48501-1511
Phone: (888) 327-0671
Fax: (810) 600-7942

Email: HAFlexSpending@mclaren.org

FLEXIBLE SPENDING ACCOUNT (FSA)
HEALTH CARE REIMBURSEMENT ACCOUNT CLAIM FORM

Please PRINT Clearly

Employee Name			ID or Social Security Number		Group/Employer
Address Street	City	State	Zip		Contact Number ( )

☐ Please check if this is a new address

Instructions

Please read all instructions and documentation requirements on the front and back before completing this form.

1. Complete all required information on the Reimbursement Form
2. Sign and date the form
3. Keep copies of this form and the documentation for your tax records
4. Attach appropriate documentation and mail to Health Advantage

You must sign and date the claim form and attach a copy of a bill, invoice or other written statement from a healthcare provider containing the patient name, provider name and address, a description of each expense, the date on which it was incurred and the amount of the expense. Please see the reverse side for documentation requirements The IRS does not allow check copies and charge slips, "balance forward" and/or "previous balance" statements as acceptable documentation. (For orthodontia requirements see item #3 on back.) You may combine family members on one form. You must supply separate reimbursement forms for different plan years.

Date expense was incurred	Amount of reimbursement request	Description: Include brief description of expense and name of person for whom services were provided	
		Description	Name
Total Amount Requested			

I certify that:

1. The above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. All applicable insurance or other health plan benefits have been exhausted.
3. I will not deduct these reimbursements as a tax credit on my Federal Income Tax Return.
4. To my knowledge, the statements I have made on this form are true and complete.

Signature: ______________________________ **Date:** ________________

(You must sign this form to be reimbursed.)

MHA20190328

Documentation requirements for Health Care expense reimbursement

1. Expenses covered by health care plans must be submitted to all other plans under which the expense is eligible. Request reimbursement of deductibles and co-payments by submitting this form along with a copy of the Explanation of Benefits (EOB) form that shows the nature and amount of expense, date incurred and certifies the amount of expense that is your responsibility.

2. If you do not have health care plan coverage for dental or vision expenses, submit an itemized statement from your service provider showing the patient name, provider name and address, date of service, description of service and amount of charge. To be reimbursed for contact lens solutions and cleaners, you may submit a cash register receipt as long as the receipt shows a description of the item. If not, the cash register receipt you submit must be accompanied by a portion of the package with the price to verify the item purchased.

3. **Orthodontia:** For orthodontia expenses, please submit a copy of the Truth in Lending Statement, orthodontia contract or financial agreement with your initial submission itemizing the treatment and the portion of treatment occurring in another plan year.

   Submit a copy of your monthly payment coupon and/or an itemized receipt each time you request reimbursement for ongoing treatment. NOTE: The plan cannot reimburse for future service or for the portion of treatment occurring in another plan year.

4. For **prescription** co-payments, submit a copy of the prescription co-payment receipt showing the patient name, drug name, date the prescription was filled, and co-payment amount. Cash register prescription receipts or charge slips showing the prescription and the amount cannot be accepted, as we need to verify the patient name and type of drug.

5. For other expenses, always submit itemized statements. A letter of medical necessity may need to accompany some charges (i.e., massage therapy and cosmetic procedures).

THE APPEAL PROCESS: If your claim is denied in whole or in part, you may appeal by requesting a review of the denied claim. Your request must be in writing and must be submitted in accordance with the instructions set forth in the denial notice within 180 days after you receive notice of the denial. If there are two levels of appeal, you will have a reasonable amount of time described in the notice of denial in which to request a second review by the Plan Administrator. You will be notified in writing of the decision on review as soon as reasonably possible but no later than 60 days after the request for review is received. Your Summary Plan Description outlines this in more detail.