Reimbursement Request Form

1893 (10/21)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

Completion guide

This form is for the reimbursement of any out-of-pocket expenses. Documentation to substantiate purchases made with your debit card must be submitted with a copy of a Receipt Reminder. Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Step 1: Accountholder information

- Complete required fields with account holder information and follow the steps below.

Step 2a: Reimbursement information

- **Plan type:** Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Did you file online:** If a claim was filed online at bhsconsumer.lh1ondemand.com, mark "Y" for yes; if not, mark "N" for no.
- **Date(s) expense(s) incurred:** Provide the date or range of dates the expenses were incurred.
- **Merchant/provider name:** Provide the name of the merchant or facility where the expense was incurred.
- **Name of person receiving product/service:** Provide your name or the name of the tax dependent for which the service was provided or the product was purchased.
- **Claim amount:** Provide the total amount requested for the specified expense.
- **Total reimbursement requested:** Total the amounts in the "Claim Amount" boxes.

Step 2b: Dependent care provider signature and certification

- Should the daycare provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Step 3: Participant certification

- Sign and date the form after reading the Participant Certification.

Documentation requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (Please be advised: if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider
- For Adult Care Services, a letter from the doctor or a Medical Necessity form is required to identify that the dependent is physically or mentally disabled and unable to self-care.

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the copayment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "copayment" is not clearly identified, have the provider write "copayment" on the receipt and sign it.

Instructions:

1. Complete all sections of this form.

2. Securely email, mail or fax completed form and supporting documentation (see below) to:

Secure Email: BenefitHelpSolutionsCDHSupport@healthaccountservices.com

Address: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108

Fax: 855-778-9837

3. If you have any questions about completing this form, please contact BenefitHelp Solutions Consumer Services at (855) 378-0197. We have representatives available Monday-Friday, 7:00am to 7:00pm CST.

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Section 1 Account holder information

* First name	M.I.	* Last name	* Date of birth _____ / _____ / _____	* Social Security number

* Mailing address	* City	* State	* ZIP
* Physical address	* City	* State	* ZIP

* Email address	* Contact phone number

* Employer
Corvallis School District

Section 2 Reimbursement information

2a) Claim information

**Please select only one to start, change, or stop reimbursement.*

* Plan type[1]	* Did you file online (Y or N)	* Date(s) expense(s) incurred	* Merchant/provider name	* Name of person receiving product/service	* Claim amount
					$
					$
					$
					$

[1] Plan types: FSA-Flexible Spending Account; DCA-Dependent Care Account; LFSA-Limited Flexible Spending Account; HRA-Health Reimbursement Arrangement

*** Total reimbursement requested** = 0.00

2b) Dependent care provider signature and certification (dependent care claims only)

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your daycare provider must complete this step. If you would prefer to file only one claim for the plan year, please access the Recurring Dependent Care Request Form at www.BenefitHelpSolutions.com.

* Dependent's name	* Dependent's Social Security number	* Dependent's date of birth (mm/dd/yyyy)	* Service type (choose one)
		_____ / _____ / _____	☐ Child care ☐ Adult care**

* If choosing adult care as an expense, please submit a medical necessity form if you haven't already.

I certify the information provided above is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

* Dependent care provider signature	* Date

Section 3 Participant certification

I certify that the reimbursement request I am submitting are eligible expenses as defined by the IRS and I have not been previously reimbursed for these expense, nor am I seeking reimbursement for these expenses from any other source. I understand BenefitHelp Solutions, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. I certify that the reimbursement is for the purpose of a qualified expenditure for an eligible individual as defined by the Internal Revenue Service (IRS) code. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify BenefitHelp Solutions. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

* Participant signature	* Date