

Health Care & Dependent Care Reimbursement Request

Part I: Employee Information (Please Print)

Page 1

Company Name _____

Employee Name (Last, First, MI) _____

Employee Soc. Sec. No. _____

Daytime Phone Number _____

Part II: Health Care Expenses – Itemize claims by date of service

Patient's Full Name	Relationship	Type(s) of Service (Medical, Dental, Vision, Prescriptions, etc.)	Date of Service	Reimbursement Request Amount	For Internal Use
1.					A__ R__
2.					A__ R__
3.					A__ R__
4.					A__ R__
5.					A__ R__
6.					A__ R__
Total					

Part III: Dependent Care Expenses

Dependent's Full Name	Date of Service		Reimbursement Request Amount	For Internal Use
	From	To		
1.				A__ R__
2.				A__ R__
3.				A__ R__
4.				A__ R__
Total				

Part IV: Affidavit of Dependent Care Services Rendered

I have provided adult/child care for _____ for the period beginning _____
 (Dependent's Name)
 and ending _____ Services were provided to _____
 (Employee's Name)
 for a fee of _____

Signature of Care Giver _____ Tax ID# or SS# _____ Date _____

Part V: Employee's Certification For Reimbursement
I hereby certify that:

- The above information is correct and true, and I have not requested reimbursement for drugs/medicines that are not within the IRS/DOL approved guidelines as adopted in **September of 2003**; and
- I have not previously received reimbursement for these expenses from my Flexible Spending Account(s) or any other plan; and
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than \$5,000.

I understand that:

- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return; and
- Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Flexible Spending Account(s).

I hereby authorize Martin Benefit Administrators Inc. or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent care providers, pharmacies, employers, and all other agencies or organizations (this includes other insurers) to consider this claim for reimbursement under my Flexible Spending Account(s).

Employee Signature _____

Date _____

FAXED REQUESTS WILL BE ACCEPTED – (952) 541-3639

This form must be accompanied by your initial signed claim form. Use this additional form for itemizing your medical claims when all the space provided on your initial form has been used. If this form is received without your **initial signed claim form, we will deny your request and return it to you for proper submission .**

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Patient's Full Name	Relationship	Date of Service	Type(s) of Service (Medical, Dental, Vision, Prescriptions, etc.)	Reimburse-ment Request Amount	For Internal Use
7.					A__R__
8.					A__R__
9.					A__R__
10.					A__R__
11.					A__R__
12.					A__R__
13.					A__R__
14.					A__R__
15.					A__R__
16.					A__R__
17.					A__R__
18.					A__R__
19.					A__R__
20.					A__R__
21.					A__R__
22.					A__R__
23.					A__R__
24.					A__R__
25.					A__R__
26.					A__R__
27.					A__R__
28.					A__R__
29.					A__R__
30.					A__R__

Total: _____

Employee Signature _____ Date _____

Medical and Dependent Care Reimbursement Procedures

To expedite the processing of your medical and dependent care reimbursements, here are some help full tips for completing the claim form.

1. **Part 1** of the claim form should be completed in its entirety. The daytime phone number should be a number where you can be reached during *business hours*. Many times questions will arise that can be answered by a phone call and do not require any written correspondence.
2. Receipts that show only the BILLING DATE, STATEMENT DATE, PREVIOUS BALANCE, OR BALANCE FORWARD are not acceptable receipts. Receipts must show the actual date of service along with the description of the service. Eligibility is determined by the date of service, not the payment date or billing date. The receipt must also show the name of the service provider.
3. **CANCELLED CHECKS AND CREDIT CARD RECEIPTS ARE NOT ACCEPTABLE RECEIPTS**
4. Remember that in order for an expense to be eligible for reimbursement, it must be for the Prevention or alleviation of a physical or mental condition. A licensed professional must request the procedure and prescribe any medicines or drugs. Products or services that are merely beneficial to the general health of an individual are not eligible expenses.
5. Any surgeries, medical or dental procedures such as Bleaching and Whitening of the teeth are considered Cosmetic in nature and are not eligible expenses. Massage therapy may to an eligible expense only when it is a prescribed by a physician. This type of request must be supported by a physician's note describing the illness or medical condition that the massage is necessary to treat.
6. The receipt for OTC expenses must include, at a minimum, a description of the product, the date of the Expense and the name of the provider along with the amount. All items must be clearly defined on the receipt. Store brands normally do not identify the product. If that is the case additional documentation is needed such as a copy of the product label or packaging.
7. **When submitting dependent care requests**, remember that you will not be reimbursed until the service dates requested have occurred, and the funds are available in your account. If submit a claim for the period 01/01/2006 through 01/31/2006, you will not be reimbursed until after 01/31/2006 even if the funds were previously available. Dependent Care expenses must be submitted with an accompanying receipt showing the dates of service, amount, name of provider and tax ID# or social security number of the provider. If a receipt is not with the request PART IV of the claim form **MUST BE COMPLETED IN ITS ENTIRETY**. We will not be able to accept the request without all the necessary information.
8. Before submitting your request, please make sure that all the information is legible (who what when and Where). Make sure that you have itemized your request by type of service and date. Requested amounts should not be lumped together by individual, service or date, but listed separately to avoid duplications. There is a page 2 of the claim form to be used when submitting more that 6 requests. We will not be able to accept items that are not broken out by individual date and service. Faxes are acceptable but they must be eligible. Register receipts and receipts that are on shaded or colored paper do not fax clearly. Items that are highlighted are received as if they were blacked out because they can not be read at all.

Following the above procedures will avoid unnecessary delays in processing your reimbursement. Requests **MUST** be received by **4:00PM Friday** in order for a check to be cut Tuesday morning and dated Friday. All requests received after 4:00PM will be processed for checks the following Tuesday.

If there are any questions regarding eligible receipts and items please do not hesitate to contact us.

Thank you
MARTIN BENEFIT ADMINISTRATORS -
Anne Bilancia
Direct Dial – 952-253-6221
Fax – 952-541-3639

Mailing Address:
Martin Benefit Administrators, Inc.
600 Highway 169 South Suite 1575
Minneapolis, MN 55426