HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT REQUEST



To send scanned claims, or for additional forms, go to: www.askallegiance.com

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Please print legibly in black or blue ink.						
EMPLOYER NAME:		TOTAL NUMBER OF PAGES SUBMITTED:				
EMPLOYEE NAME:		ATTENTION:				
PARTICIPANT ID: (Social Security Number or, if assigned, Allegian	ice ID)	COMMENTS:				
You may check the status of your claim, within 48 h reimbursement within two weeks, please contact ar				riance.com. If you have not received		
If you would like futu include a voided ch			ed into your bank acc on the Allegiance web			
List the medical, dental o you have to pay after in s	or vision serv	ices and expense its share. Insuran	ice premiums are not	t eligible.		
TYPE OF EXPENSE		SERVICE DAT	ES	AMOUNT REQUESTED		
MEDICAL REIMBURSEMENT REQUESTED*		TO _				
PRESCRIPTION REIMBURSEMENT REQUESTED	FROM	TO _	\$_			
VISION REIMBURSEMENT REQUESTED	FROM	TO	\$_			
DENTAL REIMBURSEMENT REQUESTED	FROM	TO	\$_			
ORTHODONTIA REIMBURSEMENT REQUESTED (Ortho contract available on website.)	FROM	TO	\$_	\ 		
	TOTAL	. REIMBURSEMEN	IT REQUESTED \$_			
Include independent, third-party documentation of insurance, attach a copy of the explanation of benef submission to insurance, send a copy of a bill or inv is not attached, your reimbursement may be delayed	its (EOB) from	m your insurance	company. For expense	es that are not eligible for		
I certify that the claimed expenses were incurred to die dependents, and/or spouse. These expenses have not p other health plan. I understand that items purchased n reimbursed through my health FSA may not be claimed	agnose, cure, to previously bee nerely to prom	n reimbursed unde ote general health	er any plan and I will n	not seek reimbursement under any		
Signature (required):		Dat	ie:			
Check here if your address has changed.						
New address:		V				
**Plages inform your employer if your address has						

*Over-the-counter drugs and medicines are not reimbursable unless prescribed by a medical practitioner.

2014

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FILING A CLAIM

Please read these important reminders for quick and efficient reimbursement:

- Please make sure to fill out your form completely (employer, ID#, your name). Documentation must include service dates, service description and charges for services received.
- Combine all like reimbursement requests. For example, If you are submitting several prescription receipts for reimbursement, enter the range of dates over which the purchases were made and the total of all the receipts on the prescription line:

Prescription Reimbursement Request

From: 7/1/12

To: 7/31/12

\$145.78

- Service dates must be within the plan year to be eligible expenses. If your employment terminates during the plan year, service dates must be within the plan year **and** while you were an active participant in the plan (ie: eligible and making contributions).
- If the service is eligible for insurance, an explanation of benefits must accompany the claim form, unless the bill from the provider shows the amount that insurance has paid, or the receipt is clearly a co-pay amount. Bills from providers that estimate insurance payment will not be reimbursed.
- If the reimbursement requested is not eligible for submission to insurance for reimbursement consideration, a bill or receipt showing date, service and charges is adequate documentation of the expense, as long as there is no reference to insurance coverage on the bill or receipt.

Eligible claims received must total at least \$1.00 before a check will be mailed or an electronic deposit initiated by Allegiance.



SAVE TIME!

Direct deposit is a convenient and easy way to receive your flex reimbursement - see www.askallegiance.com and sign up today!