REIMBURSEMENT CLAIM FORM

Limited Purpose FSA

Dental and Vision Expenses only

HSA Compatible

To: Benefit Administration Company, LLC
Attention: Flex Claims Processing
Fax: (206) 682-8016
Phone: (206) 625-1800 or (800) 967-3709 Ext. 307
E-mail: flexcs@baclink.com

Company Name: ______________________________

Participant Name: ______________________________

Date: ______________________________

Mailing Address ______________________________

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Email Address: ______________________________

Daytime Phone Number: ______________________________

Dental and Vision only

Acceptable documentation is:
1) Explanation of Benefits (EOB) from the insurance company; 2) Statement or bill from the dental or vision provider that shows date of service, services provided, patient name, and your financial responsibility.

INSTRUCTIONS

Fill in the information below for dental and vision expenses incurred by you or your eligible dependents. A copy of a receipt or bill must accompany each expense being submitted which states: the date of service, service provided, provider, patient, and cost. *Do not attach receipts or bills that do not identify your expense as a dental or vision.* Please keep a copy for your records.

Description of Expense:

Date Expense Incurred	Name & Relationship of Person Incurring Expense	Description of Service/Expense	Name of Service Provider	Your Expense
				$
			Total	$

Fax or scan and email legible copies of your receipts with this cover sheet. Keep original receipts for your records. You may also upload claims to your account within the WealthCare Portal.

CERTIFICATION BY THE PLAN PARTICIPANT

I certify that I am responsible for the validity of these receipts and that the expenses listed are not eligible for further reimbursement under any other health plan. I further certify that I have not and will not claim the listed expenses as an income tax deduction.

Signature of Participant ____ Date ____________