Health Flexible Spending Account (FSA) Reimbursement Request



To send scanned claims, or for additional forms, go to: www.askallegiance.com Please print legibly in black or blue ink.

ease print legibly in black of blue link.			
Employer Name:		Total Number of Pages Submitted:	
Employee Name:		Attention:	
Participant ID: (Social Security Number or, if assigned, Allegiance ID)		Comments:	
Faxed and mailed claims may take longer to reimbursement occurs. For quick and easy p reimbursement within two weeks, please cor	rocessing, please	e login online to submit your	claim. If you have not received
To receive reimbursement faster sign up for	direct deposit o	nline.	
PLEASE SEE REVERSE FOR CLAIM FILING II List the medical, dental or vision services and share. Insurance premiums are not eligible.		ou and your family that you h	nave to pay after insurance pays its
Type of Expense	:	Service Dates	Amount Requested
Medical Reimbursement Requested	From	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	То	\$
	Total	Reimbursement Requested:	\$
Include independent, third-party documents covered by insurance, attach a copy of the eare not eligible for submission to insurance, charges. If required documentation is not at	xplanation of be send a copy of a	enefits (EOB) from your insu a bill or invoice identifying t	rance company. For expenses that he service, service date, and total
I certify that the claimed expenses were incumyself, my qualified dependents, and/or spo I will not seek reimbursement under any other health are not reimbursable. I further understay individual tax return.	use. These exper er health plan. I u	nses have not previously bee understand that items purcha	n reimbursed under any plan and ased merely to promote general
Signature:		Date:	
☐ Check here if your address has changed.			
New address:			

2021

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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: 7/1/17 To: 7/31/17 \$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 \$5.00 before a check will be mailed. Electronic payments do not have a minimum reimbursement.



Save Time!

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