



P. O. Box 4346, Missoula, MT 59806

LIMITED HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) REIMBURSEMENT REQUEST

To send scanned claims, or for additional forms, go to:

www.allegianceflexadvantage.com

FAX: 406-523-3149 or, toll-free 877-424-3539 PHONE: 406-721-2222 or, toll-free 877-424-3570

Please print legibly in black or blue ink. Do not include day care expenses on this form.
Do not use a highlighter on this form.

Employer Name: _____	Total # of Pages Submitted: _____
Employee Name: _____	Please call to confirm receipt? Yes
Employee ID: _____ (Social Security Number or, if assigned, alternate ID)	Return Phone Number: _____ - _____ - _____
Comments : _____	Attention: _____

PLEASE SEE REVERSE FOR CLAIM FILING INSTRUCTIONS. List eligible dental or vision services and expenses for you and your family. Only list the amount of the expense you have to pay **after insurance** pays its share. Insurance premiums are not eligible.

<u>TYPE OF EXPENSE</u>	<u>SERVICE DATES</u>	<u>AMOUNT REQUESTED</u>
Vision Reimbursement Requested	From _____ To _____	\$ _____
Dental Reimbursement Requested	From _____ To _____	\$ _____
Orthodontia Reimbursement Requested (Ortho contract available on website.)	From _____ To _____	\$ _____
<u>TOTAL REIMBURSEMENT REQUESTED</u>		\$ _____

Include independent, third-party documentation of your expenses with this claim form. If any of these expenses were covered by insurance, attach a copy of the explanation of benefits (EOB) from your insurance company. For expenses that are not eligible for submission to insurance, send a copy of a bill or invoice identifying the service, service date, and total charges. If required documentation is not attached, your reimbursement may be delayed.

I certify that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my qualifying dependents, and/or spouse. These expenses have not previously been reimbursed under any plan and I will not seek reimbursement under any other health plan. I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed through my health FSA may not be claimed on my individual tax return.

Signature (required): _____ Date: _____

Check here if your address has changed. New address: _____

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 dental receipts for reimbursement, enter the range of dates over which the services were provided and the total of all the out-of-pocket expenses on the dental line:

Dental Reimbursement Requested From: 7/1/2009 To: 7/31/2009 \$ 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 your claim is covered by insurance, an explanation of benefits must accompany the claim form, unless the bill from the provider shows the amount that insurance has paid. **Bills from providers that estimate insurance coverage 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 \$15.00 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.allegianceflexadvantage.com and sign up today!