Health Care Flexible Spending Account Reimbursement Request Form - HR

(See instructions on reverse side)

A. EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY NUMBER ***(Required)***	EMPLOYER NAME ***(Required)***		ACCOUNT NUMBER(S)
LAST NAME	FIRST NAME		
ADDRESS	CITY	STATE	ZIP/POSTAL CODE

B. HEALTH CARE EXPENSES

PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE:

DENTAL COVERAGE? ☐ YES* ☐ NO

MEDICAL COVERAGE? ☐ YES* ☐ NO

VISION COVERAGE? ☐ YES* ☐ NO

* IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.

PATIENT NAME	**PROVIDER NAME AND ADDRESS** ***(i.e., Doctor Name/Pharmacy Name)***	**DATE(S) OF SERVICE**	**TYPE OF SERVICE**	**(A) TOTAL CHARGE**	**(B) AMOUNT PAID BY OTHER SOURCES** ***(i.e., Other Insurance, Medicare, etc.)***	**(C) AMOUNT TO BE REIMBURSED (A - B = C)**
				Total Reimbursement Request:		**$**

C. CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- **They were incurred for health care services or supplies provided to me or my eligible dependents.**
- **They were incurred for health care services or supplies furnished on or after the effective date of my health care flexible spending account.**
- **I have not been, nor do I expect to be, reimbursed for these expenses from any other source.**

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted and will not deduct on my individual income tax return any of the expenses reimbursed through my Health Care Flexible Spending Account. I understand that reimbursement will be made in accordance with the provisions of the Flexible Spending Account Plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

EMPLOYEE SIGNATURE ***(Required - unsigned Reimbursement Request Forms will not be considered for reimbursement)***	DATE

INSTRUCTIONS

- COMPLETE SECTIONS A, B AND C IN THEIR ENTIRETY - UNSIGNED REIMBURSEMENT REQUEST FORMS WILL NOT BE CONSIDERED FOR REIMBURSEMENT.
- IF EXPENSE IS COVERED BY INSURANCE, SUBMIT TO APPROPRIATE CARRIER(S).
- ATTACH EXPLANATION OF BENEFITS (EOB) FROM THE INSURANCE CARRIER(S) OR CO-PAY RECEIPTS.
- EACH RECEIPT MUST BE INDIVIDUALLY ATTACHED TO ONE BLANK SHEET OF PAPER IF IT DOES NOT FIT THE STANDARD PAPER FORMAT.
- IF YOU ARE SUBMITTING AN ITEMIZED BILL ONLY, INDICATE WHY THIS BILL HAS NOT BEEN PAID BY YOUR INSURANCE PLAN(S).
- ITEMIZED BILLS SHOULD INCLUDE THE FOLLOWING:
  - Provider Name and Address
  - Patient Name
  - Itemized Charges
  - Date of Service
  - Type of Service
- KEEP A COPY OF COMPLETED REIMBURSEMENT REQUEST FORMS AND THE ATTACHED DOCUMENTATION.
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS, AND BALANCE DUE BILLS ARE **NOT ACCEPTABLE** PROOF OF EXPENSES.
- IF YOU HAVE ANY QUESTIONS, PLEASE CALL: 1.800.CIGNA.24 OR THE 800 # PROVIDED ON THE BACK OF YOUR IDENTIFICATION CARD.
- FOR GENERAL INFORMATION/REQUEST FORMS, VISIT OUR WEBSITE: **www.cigna.com/fsa**
- MAIL COMPLETED FORM ALONG WITH APPROPRIATE DOCUMENTATION TO:

  CIGNA HEALTHCARE
  P.O. BOX 5200
  SCRANTON, PA 18505-5200
- ALL REIMBURSEMENTS ARE PAID TO THE EMPLOYEE.

ADDITIONAL INFORMATION

(If applicable, please use this space to explain why this bill is not being paid by your insurance plan(s).)