For Internal Use Only: *Plan Year 1* *Plan Year 2*

HEALTH CARE REIMBURSEMENT ACCOUNT CLAIM FORM

Note: For First Time Orthodontics Claim, also see Orthodontic Worksheet

EMPLOYEE: _____ **SOCIAL SECURITY #**_____

EMPLOYER:_____ **Email:**_____

HOME ADDRESS:_____

☐ *Please **X** if new address* *Street/Apt No.* *City* *State* *Zip*

HOME PHONE:_____ **WORK PHONE:**_____

The following documentation must accompany this claim form:

If expense is:	**Attach:**
▪ Covered by insurance *(including amounts applied to deductible)*	Explanation of Benefits **(EOB)**
▪ Not covered by insurance	Itemized receipt
▪ Office visit co-pay	Itemized receipt
▪ Prescription co-pay	Itemized receipt

Itemized receipt must document:
(☹*Cancelled checks are not acceptable receipts)*

- ➢ Date service was performed
- ➢ Description of service
- ➢ Service provider's name
- ➢ Service provider's address
- ➢ Person for whom service was provided
- ➢ Out-of-pocket cost to you

For each expense provide the following information (*Remember:* ***Retain a copy of claim form & receipts for your records)***

	Date of Service	Type of Expense: Medical	Prescription	Vision	Dental	OTC	Expense covered by insurance: Yes **Please submit EOB**	No	Is this a Co-payment: Yes	No	**Description of Service** or Comments *(Optional)*	**Amount of Out-of Pocket Expense**	*For Office Use Only* *Adjust*
1													
2													
3													
4													
5													
6													
7													

Total of claims	**$**
BRI adjustments	
BRI claims paid	

CERTIFICATION:

I certify the expenses on this Claim Form:

- are accurate and true
- are for a person covered under this Plan
- are eligible expenses which have not been previously reimbursed under this or any other benefit plan
- will not be claimed as an income tax deduction

Employee Signature:_____ **Date**:_____

I hereby authorize Benefit Resources, Inc. or its representatives to obtain information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement from my Flexible Spending Account.

Benefit Resources, Inc.

4775 E. 91st Street, Suite 100 Tulsa, OK 74137-2805

Phone: (918) 481-6161 1 (800) 339-7493 (Toll Free)

Fax: (918) 481-6181 1 (866) 364-7052 (Toll Free)

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You may email scanned claims to: claims@britulsa.com

Print Form