Request for Reimbursement from FSA or HRA

PO Box 2797 ◆ Portland, OR 97208-2797
Phone (541) 485-7488 ◆ (800) 422-7038
FAX (866) 446-6090
Submit claims electronically through MyFlex at:
PacificSource.com/PSA

EMPLOYEE INFORMATION

Employer _____ 11-digit Member ID _____

Employee Last Name _____ First Name _____ Middle Initial _____

Employee Mailing Address (Street) _____ (Apt. #) _____ (City) _____ (State) _____ (ZIP) _____

Home Phone _____ Work Phone _____ Email Address _____

☐ Please check if address above is new

If your plan allows a grace period and your eligible expenses occurred within that period, you have two choices:
☐ Process from current plan year ☐ Process from previous plan year (default if no box is marked)

REIMBURSEMENT REQUEST

Per IRS guidelines, please attach appropriate documentation (explained on the reverse of this form). One form may be used for multiple expenses. Do not send original documentation.

HRE = Unreimbursed Health-Related Expense, e.g., deductibles, copays, prescriptions, dental, vision, etc.
OHP = Other Health-Related Premium, e.g., insurance premiums for individual health, dental, vision, cancer policies, etc.

Type of Expense (Check one)

HRE	OHP	Amount	Service Date	Brief Description
☐	☐	$_____	_____	_____
☐	☐	$_____	_____	_____
☐	☐	$_____	_____	_____
☐	☐	$_____	_____	_____
☐	☐	$_____	_____	_____
☐	☐	$_____	_____	_____
☐	☐	$_____	_____	_____

Dependent Care Expense	Amount	Period of Service	Signature of Provider*
(Childcare and/or pre-school to age 13, adult daycare)	$_____	_____	_____
	$_____	_____	_____

Total Reimbursement Requested **$**_____

**Signature of provider is necessary only if sufficient documentation is not available (see reverse for more information.)*

AUTHORIZATION

To the best of my knowledge, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred for eligible plan participants during the applicable Plan Year. I certify that these expenses have not been, nor are they expected to be, reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I have read and understand the information provided on the reverse of this form. I authorize my flexible spending account or health reimbursement arrangement to be reduced by the amount requested above.

_____ _____

Employee Signature (required) Date

Total number of pages faxed:

REIMBURSEMENT REQUEST INSTRUCTIONS

Please complete all information on the reverse of this form, and follow the instructions below. *One form may be used for multiple expenses.* You may mail or fax your request to us, or you may submit your claim electronically at www.pacificsource.com/psa. If you have a question or need assistance in filing this form, you are welcome to call us at (541) 485-7488 or (800) 422-7038 and we will be happy to assist you.

UNREIMBURSED HEALTH-RELATED EXPENSES

1. After completing the Request for Reimbursement Form, attach a copy of insurance Explanation of Benefits (EOB) or bills/account histories for services you have received. Documentation submitted must include:
    a. The date(s) of service
    b. A description of the charge
    c. The amount you are responsible for paying (charges less insurance and discounts).

    Finance charges and interest fees are not eligible.

2. If a service has been partially covered by insurance, send a copy of the Explanation of Benefits (EOB) received from the insurance company. Include *only* the amount you will actually be paying for a service. PacificSource Administrators cannot reimburse you for amounts that will be paid by insurance.

3. Third party verification is required; therefore, cancelled checks and/or check copies may not be used as documentation.

4. Please retain originals of the bills/forms submitted for your personal tax records. We store documents electronically and destroy the originals after processing; therefore, originals will not be returned to you. Incomplete Reimbursement Request Forms, or those received without proper documentation attached, cannot be processed—if this happens, you will receive a letter of explanation.

5. In certain instances, statements from your healthcare provider may be necessary to verify the medical necessity of the procedure or prescription. Please call if you have questions.

OTHER HEALTH-RELATED INSURANCE PREMIUMS

1. After completing the Request for Reimbursement Form, attach a copy of the bill showing the insurance carrier's name, period of coverage, and the amount you are responsible for paying. A description of the type of coverage (dental, health and/or vision) should be included under "brief description."

2. Third party verification is required; therefore, cancelled checks and/or check copies may not be used as documentation.

3. Please retain originals of the bills/forms submitted for your personal tax records. Refer to #4 above for more information.

DEPENDENT CARE EXPENSES

1. After completing the Request for Reimbursement Form, attach a copy of the bill showing the Provider's name, period of service, and the amount you are responsible for paying. Childcare expenses may be submitted for children up to the age of 13.

2. Third party verification is required; therefore, cancelled checks and/or check copies may not be used as documentation. If your daycare provider does not provide documentation, you may provide the information on the front of our Request Form. If they do not provide you with their own form of documentation, your daycare provider must sign the front of the Request Form where indicated each time you submit a claim (photocopied signatures are not accepted).

3. Please retain originals of the bills/forms submitted for your personal tax records. Refer to #4 above for more information.