valueHealth
Benefit Administrators

Section 125 Claim Reimbursement Form

You can submit claims online at https://benefitmanagementllc.com or download the Benefit Management Flexible Spending Account mobile app.

Section 1. General Account Information

Employee Last Name: _____ First Name: _____ MI: _____

Employee Social Security Number: _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: ( ) _____ Name of Employer: Barton Community College BMI179

Section 2. Claim Filing Instructions

Submit the following for expense reimbursement:

1. Completed *Section 125 Claim Reimbursement Form*.
2. Copy of your service/claim receipt (sufficient information for proof of eligible expense is required). An Explanation of Benefits from an insurance company may qualify. Keep a copy for your records.
3. Physician's prescription or statement of medical necessity for any over-the-counter medication.

KEEP YOUR ORIGINAL RECEIPT; the IRS may require proof of expenses during an audit.

MAILING INSTRUCTIONS: Mail this submission:

Benefit Management, LLC/Attn: FSA Claims Dept./P.O. Box 1090/Great Bend, KS 67530
P: (888) 922-4622/ F: (620) 792-7053

Section 3. Claim Detail Information

Please complete a separate claim form for each family member. Submit total reimbursement amounts.

HEALTH CARE EXPENSES			
Date(s) of Service	**Claimant**	**Type of Service**	**Reimbursement Amount**

DEPENDENT CARE EXPENSES		
Date(s) of Service	**Provider's Signature (required if receipt is not provided)**	**Reimbursement Amount**
Provider Tax ID or SSN (required)	**Provider's Address**	**Age of Dependent(s) at Time of Service**

Section 4. Employee Authorization

This is to certify that my statements on this Reimbursement Form are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Section 125 Flexible Spending account. I am claiming reimbursement for eligible expenses incurred during the applicable plan year for myself, spouse and/or dependents. The Medical Expenses I am submitting have not been reimbursed or are not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction.

Participant's Signature: _____ **Date:** _____