FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Submit your completed form and all claim documentation (copies of ALL receipts and documentation) to Benefit Coordinators Corporation (BCC):

For the fastest reimbursement and trackable progress, submit your claims through BCC's My SmartCare:

- Mobile App
  (download from your iOS or Android app store)
- Online Portal
  https://benefitcc.wealthcareportal.com/Page/Home

Additional Submission Methods:

- Mail: Benefit Coordinators Corporation, Attn: FSA
  Two Robinson Plaza, Ste. 200, Pittsburgh, PA 15205
- Fax: 412-276-7185
- E-Mail: fsa-claims@benxcel.com *(PDF Files only, 5MB or less)*
- Download: https://secure.benxcel.com

Managing your reimbursement account has never been easier! For instant access to your account, register with My SmartCare's online portal at https://benefitcc.wealthcareportal.com/Page/Home or download the free My SmartCare mobile app from your Apple or Android device.

EMPLOYER:	GROUP NUMBER:	NUMBER OF PAGES (including receipts):
EMPLOYEE NAME:		LAST 4 DIGITS OF SSN:
EMPLOYEE STREET ADDRESS: ☐ *Please check if this is a change in address since you last submitted a claim.*		

CITY:	STATE:	ZIP:	E-MAIL ADDRESS:
HOME PHONE:	WORK PHONE:		FAX NUMBER (return correspondence):

IRS HEALTH CARE ACCOUNT EXPENSES

If a health care charge is eligible for full or partial reimbursement from an insurance carrier, the charge must be submitted to all applicable insurance carriers before this Plan can make payment. Once the claim has been processed by the insurance carrier, attach your Explanation of Benefits statement (EOB) with an itemized receipt. If the charge does not need to be submitted to an insurance carrier (copays, prescription copays, eligible over-the-counter drugs, etc.), attach your itemized receipt. Do not attach checks or credit card receipts, as the IRS does not recognize these as valid receipts.

DATE OF SERVICE (MM/DD/YYYY)	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	RECIPIENT OF SERVICE	RELATIONSHIP TO EMPLOYEE	NET AMOUNT
					$
					$
					$
				TOTAL (required):	$

DEPENDENT CARE ACCOUNT EXPENSES

Attach a copy of the invoice and receipt. Provider's signature is required if there is not a receipt attached.

PROVIDER NAME:	SSN or TIN#:
PROVIDER FULL ADDRESS:	
DATE(S) OF DEPENDENT CARE PROVIDED:	PROVIDER SIGNATURE (In lieu of receipt):_____
TOTAL CLAIM AMOUNT: $	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH:**

MEDICAL MILEAGE REIMBURSEMENT

You are only eligible for this reimbursement under a Healthcare FSA Plan. These expenses are not eligible under a Limited Purpose FSA unless the deductible of your HDHP has been satisfied. Attach a copy of receipts showing the services rendered on the date in which you are claiming mileage reimbursement. Mileage, bus, train, taxi, parking fees at the service provider location, and tolls are reimbursable.

Total Miles Traveled To/From Service Provider:	miles x 0.22 cents per mile (Subject to IRS rates)

To the best of my knowledge and belief, my statements in this form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

If this request is missing any vital information, you will receive an Explanation of Benefits (EOB) denying your request with an explanation of the additional information needed to complete the reimbursement. It's imperative that you sign the reimbursement form to avoid a denied request.

EMPLOYEE SIGNATURE (Required) _____ DATE _____