



# FLEXIBLE SPENDING ACCOUNT HEALTH CARE EXPENSE CLAIM FORM

FAX TO: 303-221-2785  
IT IS NOT NECESSARY TO INCLUDE A COVER SHEET

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## PLAN & EMPLOYEE INFORMATION

Check here if you have an address or name change

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAYTIME PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ PLAN YEAR: \_\_\_\_\_

## HEALTH CARE EXPENSES

\*\*\*\*\*PLEASE DO NOT INCLUDE PBS BENEFITS CARD TRANSACTIONS ON THIS FORM\*\*\*\*\*  
\*\*\*\*\*PLEASE DO NOT HIGHLIGHT RECEIPTS OR ITEMS ON THIS FORM IF YOU WILL BE FAXING\*\*\*\*\*

SERVICE START DATE	SERVICE END DATE	SERVICE PROVIDER	SERVICE DESCRIPTION	WHO INCURRED EXPENSE	AMOUNT
<b>TOTAL EXPENSES</b>					

If your employer has adopted the grace period (IRB 2005-42), expenses incurred during that period (typically 75 days after the plan year ends) are eligible for reimbursement from either the current or the previous FSA plan year. If you are seeking reimbursement for expenses incurred within that period, please mark one of the boxes below to indicate the plan year from which you would like to be reimbursed. If you do not mark one of the boxes, the previous plan year's balance will be exhausted.

Reimburse from previous plan year     Reimburse from current plan year

## REIMBURSEMENT INFORMATION<sup>2</sup>

Please pay this claim by Direct Deposit to my specified account already on file with PBS.

Please issue a check for this claim.

Please pay this claim by Direct Deposit using the new information provided below.

\*If you do not select a box above, your reimbursement will be processed in the manner we have on file.

I hereby authorize Planned Benefit Systems, Inc. to initiate credit entries for my Flexible Spending Account reimbursements into my account designated below and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Planned Benefit Systems, Inc. has received written notification from me of its termination in such time and in such manner as to afford Planned Benefit Systems, Inc. a reasonable opportunity to act on it.

ACCOUNT NUMBER: \_\_\_\_\_ ROUTING NUMBER: \_\_\_\_\_  
Must be 9 digits

BANK NAME: \_\_\_\_\_  CHECKING ACCOUNT     SAVINGS ACCOUNT

## EMPLOYEE AUTHORIZATION

To the best of my knowledge and belief, the expenses listed above are accurate, complete and are eligible for reimbursement under the plan. I certify that these expenses will not be claimed again when filing IRS form 1040 and that they were incurred for me or my eligible dependents. I certify that these health care expenses have not already been reimbursed under this plan or any other plan and are not reimbursable under any other coverage or employer plans. I certify that if my employer incurs a liability for failure to withhold Federal, State or local, or Social Security Taxes on one or more of my payments or reimbursements that are not Qualified Expenses, I will indemnify and reimburse the employer that liability on demand. I further certify that the over-the-counter expenses claimed above are to alleviate or treat injuries or illnesses and will not be used for cosmetic purposes or for general good health.

**PLANNED BENEFIT SYSTEMS CANNOT PROCESS THIS CLAIM WITHOUT A SIGNATURE BELOW**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Planned Benefit Systems, Inc. • [www.cci-pbs.com](http://www.cci-pbs.com)  
P.O. Box 4594, Greenwood Village, CO 80155-4594  
Customer Service 800-800-0133  
Fax 303-221-2785

## HOW TO FILE YOUR CLAIM

COMPLETE AND SIGN YOUR CLAIM FORM AND REMIT ALONG WITH RECEIPTS TO PBS IN ONE OF THE FOLLOWING WAYS:

FAX: 303-221-2785

MAIL: PLANNED BENEFIT SYSTEMS, INC.  
P.O. BOX 4594  
GREENWOOD VILLAGE, CO 80155-4594

EMAIL: [pbsclaims@cci-pbs.com](mailto:pbsclaims@cci-pbs.com)

PLEASE KEEP A COPY OF THIS FORM AND YOUR ORIGINAL RECEIPTS FOR YOUR RECORDS.

## TIPS FOR FILING YOUR HEALTH CARE CLAIMS

Submit your provider receipt(s) or an Explanation of Benefits (EOB) from your insurance company that includes the following information:

- ✓ Name of Service Provider
- ✓ Who incurred the expense
- ✓ Date of Service(s)
- ✓ Cost of Service
- ✓ Description of Service

Cancelled checks, credit card receipts or statements that only show a "Balance Due" are not acceptable forms of substantiation. The best way to ensure a claim will be reimbursed is to submit your expenses to your insurance provider (if applicable), receive an Explanation of Benefits detailing what was not covered by insurance, then submit a claim form and the EOB.

## THINGS TO REMEMBER ABOUT HEALTH CARE REIMBURSEMENTS

- Services must be rendered during the plan year while you're an active participant.
- If you have entered the plan mid-year or terminated participation, only expenses incurred while you were an active participant are eligible for reimbursement.
- You may be eligible to continue in the plan after termination, ONLY if you had a positive account balance at termination and elect COBRA.
- You will receive notification within 7 to 10 days after receipt of your claim form if your reimbursement cannot be processed for any reason.
- **Orthodontic** work is reimbursed as paid to the provider. **Submit your claims as you pay for the services** (i.e. submit claim for 25% down payment when paid and submit receipts for monthly installments as paid). We must have a receipt from the provider showing payment was made in the current plan year. Please do not send a copy of a payment schedule or a copy of a cancelled check, as they are not enough to substantiate the claim.
- **Cosmetic surgery/procedures ARE NOT** eligible expenses unless deemed medically necessary by a licensed physician. Planned Benefit Systems will require a Certification of Medical Necessity from your physician. **Teeth whitening/bleaching** is considered cosmetic and **IS NOT** eligible for medical reimbursement.
- For a more comprehensive list of "Eligible Medical Expenses", please visit our website at [www.cci-pbs.com](http://www.cci-pbs.com).

<sup>1</sup> **Email:** By providing your email address you agree to receive Employee Benefit Plan correspondence electronically. Planned Benefit Systems, Inc. does not share, sell or divulge individual private information to any third party. All individual private information, including your email address, is used solely to administer your benefit account(s). Please add our email address, [help@cci-pbs.com](mailto:help@cci-pbs.com), to your approved senders list to ensure delivery of all correspondence and notifications. You can change/delete your e-mail address by contacting the PBS, Inc. Customer Service Department or by visiting our website at [www.cci-pbs.com](http://www.cci-pbs.com). Select *Planned Benefit Systems*, then *Account Information* under the Participants section and then log in under Employee and Cardholder Login. PBS, Inc. reserves the right to utilize an email address that may be provided to us by your employer.

<sup>2</sup> **Reimbursement Information:** The initial direct deposit may take up to 10 days to process. Subsequent direct deposits normally take 2 business days from date of initiation. Bank holidays/weekends may affect when the deposit is credited to your account. Please contact your bank to verify all deposits are received. There will be a \$25 fee to reissue lost/stolen checks.

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