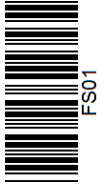




# Health FSA Reimbursement Form



Skip the form! Log into your account at [www.myonebridge.com](http://www.myonebridge.com) to submit your supporting documentation online. To submit a paper form, follow instructions provided below and send to:

**OneBridge FSA, PO Box 4391 Clinton, IA 52733-4391.** For questions, contact us at: **1-888-338-4415.**

## Section 1: Participant Information (Please fill out your benefit information below.)

Participant Number or SSN:		Date of Birth:	
Name:			
Address:			Is this a new address? <input type="radio"/>
City:	State:	Zip Code:	
Phone Number:		Email:	

## Direct Deposit Information (Please fill out your direct deposit information below.)

Bank Name:	Account Type:    Checking    Savings
Routing Number:	Account Number:

## Section 2: Reimbursement Request

- Itemize your expenses in the table provided below. Please list one expense per line and attach copies of your supporting documentation.
- Proper supporting documentation must contain the following 5 items:
  - Covered individual (patient) name
  - Date the expense was incurred
  - Service provider name
  - Description of service
  - Out-of-pocket amount to be reimbursed
- Send photocopies of your form and documentation, keep the originals for your records.
- Explanation of Benefits (EOBs) from your insurance carrier are recommended supporting documentation.
- Ensure documentation is legible. Please do not use a highlighter.
- Cancelled checks, balance forward statements, and credit card receipts do not contain all of the required information and are NOT acceptable.
- Certain types of expenses may require a Letter of Medical Necessity. For these expenses, please complete the Letter of Medical Necessity Form or attach a copy of a letter from your doctor.

## Reimbursement Details

Covered Individual	Date of Service	Description of Service	Reimbursement Amount
Self <input type="radio"/> Spouse <input type="radio"/> Dependent <input type="radio"/>			
Name:			
SSN:			
DOB:			

## Authorization (signature required to process claims)

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- The expenses listed above qualify for reimbursement under applicable IRS regulations and guidance. In the event a letter of medical necessity is required for a product or service, I have provided one as applicable.
- I am requesting reimbursement for my own personal expenses or those of my eligible dependents.
- These services have already been incurred.
- I have not and will not seek reimbursement for this expense from any other plan or party, and such expenses are not reimbursable from another source.
- I understand OneBridge Benefits reserves the right to deny a claim if I have not provided supporting documentation or if there is reason to believe the expense is not qualified as defined under the Summary Plan Description or regulatory guidance. In such instance, I may be responsible for reimbursing the plan for such expense.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_