ONEBRIDGE BENEFITS

Health FSA Reimbursement Form

FS01

Skip the form! Log into your account at **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? ☐
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 ◯ Spouse ◯ Dependent ◯ 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: _____