of Tennessee

Limited-Purpose Flexible Spending Account (LPFSA) Health Care Claim Form

- Confidential -

(Please See Instructions on Reverse Side)

Employee Information *(Please Print)*

Employee Last Name	First Name	Middle Initial	BCBST Subscriber ID Number
Employee Home Address			**Group Number**
Employer's Name			**Daytime Phone Number**
Employee E-mail Address			

-- For Address Changes, Please Contact Your Employer's HR/Benefits Department --

Limited-Purpose Flexible Spending Account
(Only available with High-Deductible Health Plan Options)

The Limited-Purpose Flexible Spending Account (LPFSA) provides tax-exempt funds you can use to pay for eligible dental and vision expenses that are not covered, or are partially covered, by your medical, dental, or vision insurance plans.

---- Please Print---- Use one line for each receipt --- Do not combine two or more receipts on one line --- Use additional forms if necessary ---

Date of Service	Name of Person Receiving Service	Name of Provider of Service	Description of Service/Supply	Requested Reimbursement Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total Reimbursement Requested	$

Employee Certification

I certify that:

- ***All eligible expenses listed above for which I am seeking reimbursement were received by me or an eligible dependent.***
- ***All the expenses listed above for which I am seeking reimbursement from the Flexible Spending Account have been incurred.***
- ***These expenses were incurred within my period of coverage during the plan year.***
- ***These expenses have not previously been reimbursed and will not be presented for reimbursement through any other health plan.***
- ***I understand that I alone am fully responsible for the accuracy of all information I have provided by submission of this claim form.***
- ***I agree to submit and retain sufficient documentation for any expenses for which I seek reimbursement as may be required by the IRS.***

Please check the box below and type your first and last name and the date in the space provided:

☐ ***I acknowledge that, by typing my name and the date below, I am signing this claim form electronically. I consent to conducting this transaction electronically, and I acknowledge that my electronic signature is the legal equivalent of my handwritten signature.***

Employee Signature **Date**

If you do not want to submit this claim form electronically, please print, sign, and return this form and supporting documentation by:	**Fax To:** 1-888-666-1221 **Email To:** HDHP_Claims@bcbst.com	**Or Mail To:** BCBST Claims Service Center 1 Cameron Hill Circle STE 0022 Chattanooga, TN 37402-0022	**Questions:** Customer Service 1-800-565-9140 *www.bcbst.com*

(See Instructions on Reverse Side)

Limited-Purpose Flexible Spending Account (LPFSA)
Claim Reimbursement Instructions

LPFSA HEALTH CARE EXPENSES:

- **LPFSA Health Care Expenses Include:**
  - Dental plan deductibles and expenses not paid by the plan.
  - Other qualified dental expenses not covered by the dental plan.
  - Vision care expenses, including qualified expenses, not covered by a health care benefit.
- **Expenses solely for cosmetic reasons or for general health and well-being are not usually eligible expenses for medical care.**

SUPPORTING DOCUMENTATION: ***Supporting third-party documentation for health care expenses must include at least one of the following:***

- **Explanation of Benefits** ***(EOB)***
  - The statement you receive each time a claim is submitted to your health, dental or vision plan.
- **Itemized Statement or Receipt Containing:**
  - Type of service or product provided*;*
  - Date the expense was incurred;
  - Name of the employee/dependent for whom the service/product was provided;
  - Person/organization providing the service/product;
  - Amount of the expense after insurance benefits were provided *(if applicable)*.

INELIGIBLE EXPENSES AND DOCUMENTATION : ***The following are not allowable under Code Section 125 of the IRS:***

- **Unacceptable Documentation:**
  - Credit card receipts or cancelled checks as documentation.
  - Billing statements showing "Previous Balance," "Balance Forward," or "Received on Account."
- **Ineligible Expenses:**
  - Amount paid by insurance.

BEFORE YOU SUBMIT YOUR LPFSA HEALTH CARE REIMBURSEMENT CLAIM FORM PLEASE BE SURE TO:

- Complete the claim form in full.
- Sign and date the claim form.
- Include the appropriate documentation, including the EOB whenever possible, to substantiate your expenses.
- If multiple items are listed on a receipt, ***CIRCLE*** the items filed for reimbursement. ***DO NOT highlight the items.***
- Make sure supporting documentation equals the total amount you are claiming for reimbursement.
- Keep a copy of your claim form and any original receipts for your records.