

Flexible Spending Medical Expense Claim Form



IMPORTANT NOTE: This form MUST be completed in order to receive reimbursement from your Medical Care Spending Account. Appropriate documentation is required and includes the date of service, patient name, amount, description of service, provider name, and patient responsibility. Examples of proper documentation include:

- Explanation of Benefits (EOB) reflecting patient liability
- Itemized statements indicating dental or vision expense(s)
- Detailed prescription receipt(s)
- Receipt for eligible over the counter (OTC) items, including date of purchase and name of the item clearly *marked*.

Please Note: All claims must be incurred during the plan year; prepayment for future dates of service is prohibited. A letter of medical necessity may be requested if item(s) are considered "dual purpose". Processing time could be delayed if proper documentation is not provided. Cancelled checks and credit card receipts are not acceptable documentation. Eligible dependents for medical expense reimbursement are considered a participant's spouse and/or unmarried dependent children who are younger than 19 (or an eligible full-time student who is under 24) at the end of the calendar year.

EMPLOYEE INFORMATION

Name: _____ SSN#/ID Number: _____
Street: _____ Phone: (____) _____
City: _____ State: _____ Zip: _____
Employer: _____

Medical Care Expenses

Date(s) of Service	Patient's Name	Provider	Amount Requested
Grand Total:			

EMPLOYEE CERTIFICATION

I, the undersigned, certify that the above expenses were incurred by me (and/or my spouse and/or eligible dependents) and have been incurred within the period of coverage during the plan year. The above expenses have been paid by me (or them), were not reimbursed by any other plan and to the best of my knowledge and belief, are eligible for reimbursement under my FLEX account. I have attached Explanation of Benefits statement(s) from all insurance plan(s) and a letter of medical necessity (when necessary) of these expenses. I understand that I cannot use the expenses reimbursed through this FLEX account as deductions or credits when filing my income tax return. If audited, I understand that it is my responsibility (not my employer's) to provide written proof that these expenses were actually incurred and eligible for reimbursement.

Employee Signature: _____ Date: _____

Unsigned claim forms will not be considered for reimbursement.



Medical Expense Spending Account Reimbursement Guidelines

Contact Information: Sioux Valley Health Plan Flexible Benefits Department
PO Box 91110
Sioux Falls SD 57109-1110
Phone: 605-328-6810
Fax: 605-328-7207
E-mail: flex@siouxvalley.org
Online Inquiry: www.svhp.com

Submitting Medical Expense Claim Forms for Reimbursements: To request a medical expense reimbursement, the participant must complete and submit the appropriate claim form, along with proper documentation to Sioux Valley Health Plan. Claim forms can be found on www.svhp.com.
Please note: Some reimbursements may require a letter of medical necessity.

Pharmacy Expenses: Proper documentation includes the receipt from the pharmacy indicating the prescription filled, the date, cost, etc.

Medical Out-of-Pocket Expenses: Proper documentation includes the Explanation of Benefits (EOB) from your insurance company, or an itemized statement showing all expenses and applied insurance payments.

Vision/Dental Expenses: Proper documentation includes itemized statements indicating the services provided, dates of service, cost, etc. If insurance is provided for any of the services, an EOB must be submitted as the participant cannot be reimbursed for any amount paid or discounted by insurance.

Over-the-Counter Expenses: Proper documentation includes cash register receipts clearly showing the item purchased.

Autoprocessing Note: If autoprocessing has been selected, the out-of-pocket expenses incurred for pharmacy copays, office visit copays, deductible or coinsurance amounts will be included in the automatic procedure. This option is elected by the employee. The autoprocessing function is performed weekly, with pharmacy processing the weeks following the 3rd and the 17th of each month. The participant should keep in mind that the provider must submit the medical claim and Sioux Valley Health Plan must adjudicate the medical claim prior to being reimbursed by the medical expense spending account.

Adds/Changes/Terminations: Election amounts and enrolled spouse/dependents will stay in effect throughout the plan year, unless a qualified life event occurs. If a qualified life event occurs, Sioux Valley Health Plan must be informed within 30 days of the qualified life event in order for eligibility changes/election changes to occur. All eligibility changes/election changes must be consistent with the qualified life event.
