P.O. Box 91110
Sioux Falls, SD 57109-1110
(605) 328-6810 / Fax: (605) 328-7207
www.sanfordhealthplan.com

FLEXIBLE SPENDING MEDICAL EXPENSE CLAIM FORM

EMPLOYEE INFORMATION

Name: ______________________ ID Number: ______________________

Street: ______________________ Phone: (______)______________________

City: ______________________ State:___________ Zip: ______________________

Employer: ______________________

PLEASE NOTE: All claims must be incurred during the plan year (unless your plan has a grace period) and prepayment for future dates of service is prohibited. Processing time could be delayed if proper documentation is not provided. ***Balance forward statements, 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.*

Medical Care Expenses:

Please check the appropriate box(es) corresponding with your claim(s):

- ☐ Charges attached are partially covered benefits under my health and/or dental insurance coverage. The charges have been submitted to my medical/dental insurance prior to this submission. Enclosed is an Explanation of Benefits from my insurance showing my out of pocket cost(s).
- ☐ Charges are not a covered benefit by any insurance plan. Enclosed is an itemized statement for this incurred service.
- ☐ Charges attached are for reimbursement of my office visit or prescription drug co-pay due at the time of service. Enclosed is an itemized receipt provided by the provider of service. I understand that my prescription drug copay receipt must indicate patient name, drug name, date of fill and amount paid.
- ☐ Charges are for orthodontia expenses. I have attached a treatment plan to this claim (or have previously filed with Sanford Health Plan).
- ☐ Charges attached are for reimbursement of an eligible over-the-counter (OTC) item. Enclosed is a detailed receipt showing the purchased OTC item. If this is considered a dual purpose item, I have attached a letter of medical necessity (or have one on file with Sanford Health Plan).

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

EMPLOYEE CERTIFICATION: Employee signature required.

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 and were not reimbursed by any other plan (including a plan from my employer) 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 employers or the plan administrators responsibility) to provide written proof that these expenses were actually incurred and eligible for reimbursement.

Employee Signature: ______________________ Date: ______________________

Did you remember to?:
- □ Sign and date your claim form
- □ Provide proper documentation
- □ Read the account guidelines on the back
- □ Retain original document for your records

Failure to complete all appropriate sections of the claim form or submit legible itemized receipts/EOBs may delay the processing of your claims.

Medical Expense Spending Account
Reimbursement Guidelines

Contact Information: Sanford Health Plan Flexible Benefits Department
PO Box 91110
Sioux Falls, SD 57109-1110
Phone: 605-328-6810
Fax: 605-328-7207
E-mail: flex@sanfordhealth.org
Online Inquiry: www.sanfordhealthplan.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 Sanford Health Plan. Additional claim forms can be found at www.sanfordhealthplan.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 Sanford 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, Sanford 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.