Mobile Upload
Electronic Claim submission:
https://secure.ebpabenefits.com
Fax: 603-773-4415
Mail To: EBPA Reimbursement Accounts
P.O. Box 1140
Exeter, NH 03833-1140
Phone: 888-678-3457

HEALTH CARE ACCOUNT

REIMBURSEMENT REQUEST FORM

NAME	SOCIAL SECURITY NUMBER (optional)
ADDRESS (STREET)	EMPLOYER
ADDRESS (CITY, STATE, ZIP CODE)	LOCATION/DIVISION

- List reimbursable expense and attach explanation of benefits or itemized bill.
- Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing), or O (Other), under Type of Expense.
- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.
- Attach a second form if you need additional space.

TYPE OF EXPENSE	EXPENSE FOR:		DATES OF SERVICE:		TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT OF REIMBURSEMENT DUE
	FIRST NAME	RELATIONSHIP	FROM	TO			
				TOTALS			

1. I certify that the above listed expense(s) have been incurred by me or my eligible dependent(s) (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE

SIGNATURE_____ DATE_____

HOW TO FILE A CLAIM FOR YOUR HEALTH CARE REIMBURSEMENT ACCOUNT

INSTRUCTIONS TO FILL OUT THE HEALTH CARE ACCOUNT REIMBURSMENT REQUEST FORM

- Complete ALL personal information requested on the form (name, address, social security number (optional), etc.)
- Use your documentation to complete ALL details relating to the claim.

See example below:

Type of Expense	Expense for Name/ Relationship	Dates of Service	Total Bill (Attach Copy)	Plan Payment (Attach Payment or Denial)	Amount of Reimbursement Due
M	**John Doe- Spouse**	**03/05/2018-03/05/2018**	**$300.00**	**None**	**$300.00**

- Type of Expense- Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing), or O (Other). If no health plan applies, write **none** in the plan payment column.
- Expense For- List full names and relationship of whom the expense is for.
- Dates of Service- List the date in which the service took place.
- Total Bill- Attach supporting documentation, such as the explanation of benefits or itemized bill.
- Plan Payment- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.
- Amount of Reimbursement Due- Calculate the amount of reimbursement due by subtracting the plan payment from the actual billed amount.
- Sign and date the reimbursement request.

WHAT SUPPORTING DOCUMENTATION WILL EBPA ACCEPT?

- EBPA will accept the following for supporting documentation- Itemized Bills, Itemized receipts, or Explanation of Benefits (EOB).

Documentation must show the following:

A. Name of the patient.
B. The date the expense was incurred (not the date paid).
C. The name of provider of services.
D. The type of service.
E. The amount of the expense for which you are responsible.

Note: Canceled checks and balance forward statements cannot be used as acceptable documentation for claim purposes.

WHERE TO SEND COMPLETED FORM?

Submit completed forms and documentation to EBPA using the following methods:

- Electronically transmitted through EBPA's Secure Document Submission Portal: https://secure.ebpabenefits.com
- Submitted online through the FSA claim system: http://forms.ebpabenefits.com/ebpabenefits/clmsonline.pdf
- Print Fax Cover Page and fax to: 603-773-4415 http://forms.ebpabenefits.com/ebpabenefits/fsa_fax.pdf
- Mobile App upload

OR

- Mail to: EBPA Reimbursement Accounts
  PO Box 1140
  Exeter, NH 03833-1140

Note: You may not claim on your Federal Income Tax Return, any health care expenses for which you have been reimbursed.

ACCOUNT INFORMATION

- All reimbursements will be made payable to you.
- Each reimbursement check stub is a statement of account.
- Statements of account will be issued annually. Statements/account information is available on-line at ebpabenefits.com.
- EBPA-You may view the status of your reimbursement online at www.ebpabenefits.com.

*If you have additional questions regarding completing the **EBPA Health Care Account Reimbursement Request Form,** please contact EBPA at 1-(888) 678-3457.*