What You Need to Submit for Health Care Expenses

This one page guide gives you all the information you need to know in order for Benefit Coordinators Corporation (BCC) to process your healthcare claim.

BCC NEEDS THE FOLLOWING TO PROCESS YOUR CLAIM:

1. A completed Request for Reimbursement Form, including the total amount you're claiming, your signature and the date.
2. Supporting documents (below are the guidelines for acceptable documentation)

CLAIMS SUBMITTED WITHOUT THE REQUIRED DOCUMENTATION WILL BE DENIED

A) Required for most health care services

- For all PPO services: An explanation of benefits (EOB) from the insurance company
- For other than PPO services: An itemized bill or receipt from the service provider that includes all of the following:
  1. Name of service provider
  2. Name of patient
  3. Date of service
  4. Details of the service or product
  5. Cost of service or product

A. Do NOT submit:

- Cash register receipts
- Balance forward statements
- Cancelled checks
- Credit card receipts and/or statements
- Received-on-account statements
- Estimates for services to be performed

B. Requred for an office co-pay

- A receipt or invoice, which includes all of the following:
  1. Name and address of service provider (must be pre-printed or stamped on receipt or invoice)
  2. Name of patient
  3. Date of service
  4. Wording indictating that this is a "co-pay" or "office visit"
  5. Cost of co-pay

B. Do NOT submit:

- Cash register receipts
- Balance forward statements
- Cancelled checks
- Credit card receipts and/or statements
- Received-on-account statements

C. Required for prescriptions

- A copy of the itemized prescription label (often attached to the outside of the bag upon purchase) or mail-order prescription invoice, which includes all of the following:
  1. Name of pharmacy
  2. Name of patient
  3. Date of purchase
  4. Name of drug (if not subject to co-pay)
  5. Cost of prescription

NOTE: If you do not retain a copy of your prescription label, please contact your pharmacy.

C. Do NOT submit:

- Cash register receipts
- Balance forward statements

D. Required for prescribed over-the-counter (OTC) medications and medical supplies

- A cash register receipt, which includes all of the following:
  1. Name of the store or pharmacy
  2. Date of purchase
  3. Name of the item
  4. Cost of the item (may include tax)
  5. Copy of prescription for OTC item

NOTE: The name of the patient is not required on a cash register receipt (for OTC items only).

E. Special Circumstances

- Orthodontia: Requires an Orthodontia Financial Agreement each Plan Year (*Call us!*)
- Some expenses require a letter from your doctor each Plan Year (*Call us!*)
  - Hypnotherapy
  - Massage Therapy
  - Support Hose
  - Viagra
  - Weight Loss

What You Need to Submit for Dependent Care Expenses

This one page guide gives you all the information you need to know in order for Benefit Coordinators Corporation (BCC) to process your dependent care claim.

BCC NEEDS THE FOLLOWING TO PROCESS YOUR CLAIM:

1. A completed Request for Reimbursement Form, including the total amount you're claiming, your signature and the date.
2. Supporting documents (below are the guidelines for acceptable documentation)

CLAIMS SUBMITTED WITHOUT THE REQUIRED DOCUMENTATION WILL BE DENIED

Dependent Care Documentation must show:

1. Name of dependent(s)
2. Beginning and ending dates of service
3. Name of service provider
4. Provider tax ID number (health care facilities) or social security number (individual service providers)
5. Amount incurred
6. The signature of an individual childcare provider

Do NOT submit:

- Copies of checks or canceled checks (copies of canceled checks are acceptable as long as both the front AND back of the canceled check are copied)
- Balance forward statements
- Credit card statements
- Estimates for services to be performed

PLEASE NOTE:

1. Reimbursement requests received incomplete or without proper documentation will be returned unprocessed.
2. You may only be reimbursed for current or previous dependent care expenses.
3. Keep originals for your records. Supporting documents become part of your claim and will not be returned.
4. Reimbursements will be sent to your home address unless the direct deposit feature is available under your Flexible Benefits Plan and is requested.
5. Cash register receipts and credit card receipts ARE acceptable, provided that they are detailed and the employee's request form is itemized.

Additional Dependent Care information:

"Dependent Care" is defined as the daycare provided to a child or children under the age of 13, or to a dependent of any age, including your spouse, who is physically or mentally incapable of caring for him or herself.

An eligible participant is:

1. a single working parent, or
2. a working parent whose spouse is also working, or whose spouse is a full-time student or is disabled.

- Eligible care is that which is provided in a home (e.g., yours or the provider's) or in a dependent care facility that complies with all state and local regulations. It may not be an overnight camp or residential facility.
- Expenses that are NOT eligible include the cost of educational programs, registration fees, fees for field trips, food, supplies, before- and after-school activities such as athletic programs, private tuition (including Kindergarten), overnight camp, and services provided by centers whose primary function is not child care (e.g., aquatic centers).
- The total amount claimed under the Plan for any coverage period must NOT exceed the lesser of your earned income for the plan year or the earned income of your spouse. If your spouse is either a full-time student or is incapable of taking care of him or herself, then he or she is deemed to have monthly earnings of $250 if there is one child or dependent, and $500 if there are two or more children.

FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT REQUEST

Please send your claims to: Benefit Coordinators Corporation (BCC)
Mail: Two Robinson Plaza, Suite 200 Pittsburgh, PA 15205-1324 | Fax: 412-276-7185 | Download: https://secure.benXcel.com
You may also scan/convert your documents to a PDF file and e-mail to: fsa-claims@benxcel.com.
(NOTE: The file size of your e-mail attachment cannot exceed 5MB.)
Visit our homepage at www.benXcel.com for easy-to-access forms! | BCC's Customer Service Center: 1-800-685-6100

EMPLOYER: City of Merced	GROUP NUMBER: CTYMER	Number of Pages (including receipts): _____
EMPLOYEE NAME: _____		Last Four Digits of SSN: _____

YOUR ADDRESS: ☐ Please check if this is a change in address since you last submitted a claim.

_____
Street

_____ _____ _____
City State Zip

NOTE: If your request is missing any vital information, BCC will send you an Explanation of Benefits (EOB) denying your request with an explanation of the additional information necessary to complete the reimbursement process. Also, it's imperative you sign your form to avoid having your request denied. For a detailed explanation of how to submit a claim for reimbursement, visit www.benxcel.com and read "Submit healthcare claim" and "Submit dependent claim" under our Forms and Brochures section. Please include copies of ALL receipts and documentation with this form.

HEALTH CARE ACCOUNT EXPENSES

If a health care charge is eligible for full or partial reimbursement from an insurance carrier, the charge must be submitted to all applicable insurance carriers before this plan can make payment. Once the claim has been processed by your insurance carrier, attach your Explanation of Benefits statement (EOB) with an itemized receipt. If the charge does not need to be submitted to the insurance carrier (office visit copays, prescription copays, eligible over-the-counter drugs, etc.) attach your itemized receipt. Do not attach checks or credit card receipts, as the IRS does not recognize these items as valid receipts for this program.

DATE OF SERVICE	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	RECIPIENT OF SERVICE	RELATIONSHIP TO EMPLOYEE	NET AMOUNT
					$
					$
					$
					$
					$
					$
					$
				TOTAL (required):	$

DEPENDENT CARE ACCOUNT EXPENSES

Attach a copy of the invoice and receipt. Provider's signature is required if there is not a receipt attached.

Provider Name: _____ SS# / TIN#: _____
Address: _____
City: _____ State: _____ Zip: _____

Dependent Name	Dependent Date of Birth:
Date(s) of Dependent Care Coverage: _____ Total Claim: _____	Provider Signature (In lieu of receipt): _____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

_____ _____
EMPLOYEE SIGNATURE (Required) DATE