Healthcare Reimbursement Form

How to file a claim:

Online: Log into your benefits portal or use the MyChoice Mobile App to submit your claim electronically

Via email, fax or mail: Fill out your form electronically and submit via email, fax, or mail.

- **Email**: claims@mychoiceaccounts.com **Fax**: 855-883-8542
- **Mail**: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168

Instructions for filling out this form:

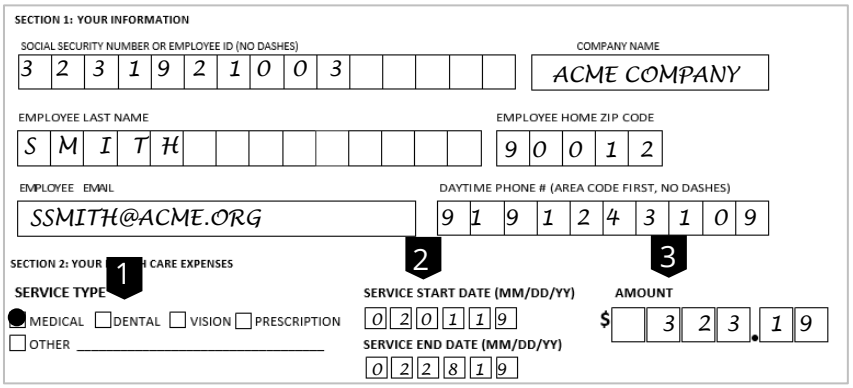
Complete each section completely. If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

1 SERVICE TYPE *(indicate the eligible service or product that is being claimed for reimbursement)*

2 SERVICE START AND END DATE

3 AMOUNT SUBMITTED FOR CLAIM



To ensure your claim is submitted successfully:

1. An employee who is enrolled in the plan, and their legal spouse or tax dependent.
2. Examples of qualifying expenses (Review IRS Publication 502 for specific questions)
    a. Flexible Spending Account: Medical, dental, vision, prescriptions, orthodontia, chiropractic, and hearing expenses not covered by your health insurance.
    b. Limited Purpose Flexible Spending Account (if you are currently enrolled in an HSA): Dental, vision, orthodontia not covered by your health insurance.

3. Be sure to attach a copy of the Explanation of Benefits, or itemized invoice(s)
    a. The date the expense was incurred (not the date paid and no future dates).
    b. The name of service provider
    c. A description of the service and/or expense.
    d. The amount of the expense for which you are responsible.

Please Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.

mychoice Accounts

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SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

COMPANY NAME

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR HEALTH CARE EXPENSES

SERVICE TYPE

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION

☐ OTHER _____

PATIENT NAME _____

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$

SERVICE TYPE

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION

☐ OTHER _____

PATIENT NAME _____

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$

SERVICE TYPE

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION

☐ OTHER _____

PATIENT NAME _____

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan
- Any expenses submitted on behalf of dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free.
- Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.

I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.