



BlueCrossBlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

REQUEST FOR REIMBURSEMENT PREFERRED HEALTH FSA/HRA

Attach a copy of the itemized bill and a Claim Processed Report (if applicable) along with proof of payment. All documentation must include the patient name, description of service provided, date provided, and the charge. Be sure to sign and date this form before sending it with all attachments to the address shown.

I certify that the attached expenses are eligible for reimbursement from my designated Health FSA/HRA and that they qualify as deductions as outlined by the U. S. Internal Revenue Code or by my employer. I request reimbursement up to the limit allowed in my account. I further certify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan. A dependent must be considered an eligible dependent under the applicable provisions of section 105 and 106 of the U.S. Internal Revenue Code.

Signature of Employee

Month

Day

Year

Important: This form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from a tax-deferred, employee-funded spending account established by your employer under Section 125 of the U.S. Internal Revenue Code or from your HRA established by your employer. Payments from such an account may only be made for qualified expenses on behalf of qualified dependents when such expenses have not been reimbursed and are not reimbursable by any other benefit plan.

Blue Cross and Blue Shield of Alabama Preferred Blue Accounts

P.O. Box 11586
Birmingham, Alabama 35202-1586
1-800-213-7930
Toll Free Fax 1-877-889-3610

Visit our web site www.bcbosal.com for
detailed account information

SECTION 1: EMPLOYEE INFORMATION

FIRST NAME

MI

LAST NAME

DATE OF BIRTH

PREFERRED BLUE ACCOUNT NUMBER

Your Preferred Blue Account number is your Blue Cross and Blue Shield of Alabama contract number. If you do not have your account number, please contact Customer Service at 1-800-213-7930.

COMPANY NAME

WORK PHONE (Please include area code)

HOME PHONE (Please include area code)

SECTION 2: HEALTH FSA/HRA REIMBURSEMENT INFORMATION

In order to be properly reimbursed, complete this section for each eligible expense and attach all necessary itemized receipts. (PLEASE DO NOT HIGHLIGHT ITEMS ON YOUR RECEIPTS.)

TYPE SERVICE

- ☐ MEDICAL
☐ VISION
☐ DENTAL
☐ ORTHODONTICS
☐ RX/OTC
☐ OTHER

PATIENT'S FIRST NAME

LAST NAME

RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT

COVERED BY INSURANCE ☐ YES ☐ NO

AMOUNT

DATE OF BIRTH

DATE OF SERVICE

TYPE CHARGE ☐ COPAY ☐ DEDUCTIBLE ☐ COINSURANCE ☐ OTHER

EOB ATTACHED ☐ YES ☐ NO

TYPE SERVICE

- ☐ MEDICAL
☐ VISION
☐ DENTAL
☐ ORTHODONTICS
☐ RX/OTC
☐ OTHER

PATIENT'S FIRST NAME

LAST NAME

RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT

COVERED BY INSURANCE ☐ YES ☐ NO

AMOUNT

DATE OF BIRTH

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LAST NAME

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COVERED BY INSURANCE ☐ YES ☐ NO

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EOB ATTACHED ☐ YES ☐ NO

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COVERED BY INSURANCE ☐ YES ☐ NO

AMOUNT

DATE OF BIRTH

DATE OF SERVICE

TYPE CHARGE ☐ COPAY ☐ DEDUCTIBLE ☐ COINSURANCE ☐ OTHER

EOB ATTACHED ☐ YES ☐ NO



TOTAL

AMOUNT

Helpful Tips for Successfully Filing a Request for Reimbursement.

1. **Complete your Request for Reimbursement Form legibly.**

If your form can not be read properly, it cannot be processed accurately.

- Do not highlight receipt items. Circle them instead.
(High-lighter when faxed or scanned can appear as black or gray)
- Only submit expenses for an eligible dependent. An eligible dependent must meet the provisions of sections 105 and 106 of the U. S. Internal Revenue Code.

2. **Provide appropriate supporting documentation.**

IRS rules state that you must provide appropriate documentation. All documentation must show:

- The date of service (the date you incurred the expense)
- The name of the service provider
- To whom the service was provided (patient's name)
- The out of pocket expense (amount you paid for the service)
- A clear and detailed service/procedure description

What is acceptable documentation?

Examples of good documentation are:

- A Claim Process Report or an Explanation of Benefits (EOB) from your insurance carrier showing the above information. If the EOB indicates the procedure is not covered by your health insurance plan, you may be required to submit an itemized statement from the provider.
- For prescription drugs, a pharmacy statement including the name of the pharmacy, patient's name, date the RX was filed, patient's cost, RX number and name of the drug.
- As of January 1, 2011, over-the-counter (OTC) medications and other "dual purpose" items will not be reimbursed without a written doctor's prescription. You must also include an itemized receipt indicating the item purchased.

Unacceptable documentation:

Bank card statements, credit card receipts, canceled checks, estimates of expenses, account balance statements and balance forward statements are not valid documentation.

3. **Sign your form.**

An unsigned form will stop your reimbursement!

4. **Fax or Mail your Form.**

Fax your request to our toll-free fax. You can also mail it if you prefer.

