Submit your claim online

Claim Submittal Options

20___ Plan Year

Flexible Saving Account (FSA) Claim Form

Employer Name____

Employee Name____

Phone # or E-mail address____

PAYMENT OR REIMBURSEMENT OF HEALTH CARE FLEXIBLE SPENDING ACCOUNT CLAIMS ARE SUBJECT TO THE PROVISIONS OF YOUR EMPLOYER'S PLAN DOCUMENTS AND APPLICABLE LAWS AND REGULATIONS!

All FSA claims must be submitted with documentation that verifies the following: (1) Date of Service (2) Patient Name (3) Provider Name (4) Type of Expense (5) Amount of Expense. If the request is for an over-the-counter drug, YOU MUST INDICATE THE NAME OF THE DRUG AND ITS PURPOSE TO TREAT THE PATIENT.

☐ FSA Medical Claim ☐ FSA Medical Limited Purpose (Dental/Vision) Claim ☐ **FSA Medical Limited Purpose Post Deductible Claim

**If you are submitting a claim for post deductible – by checking the box above you are confirming you have met the IRS minimum deductible amount for the plan year. This link will let you know the amounts you have to meet for this plan year - http://www.bbpadmin.com/docs/Participant/COLA.pdf please remember you cannot be reimbursed from your FSA and HSA plans as the IRS does not allow double dipping. By checking the box you are stating you met the IRS minimum deductible and are allowed to get medical payments from your FSA Medical Limited Purpose.

Date of Service	Patient Name	Provider Name	Expense Type Code *	Reimbursement Request Amount
				$
				$
				$
				$
				$
				$
				$
				$

TOTAL HEALTH CARE FSA EXPENSE REQUEST (this page only, use as many forms as needed): $______________

Please keep your originals and either e-mail, fax, or mail copies of your bills or receipts for the health care expenses included on this form.

*Expense Type Codes: M = Medical D = Dental V = Vision
O = Over-the-Counter P = Prescription Drugs T = Travel for Health Care

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Company's Flexible Spending Account Plan with respect to such expenses and that the health care expenses, if applicable, have not been or are not reimbursable under any other health plan coverage. I, the undersigned, certify that a federally recognized dependent or I incurred these expenses and the expenses are eligible under federal law. **I fully understand that I alone am responsible for the sufficiency, accuracy, and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state, and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses.** A copy or electronic copy of this form and all supporting documentation shall be deemed as valid as the original.

Furthermore, (1) IMPORTANT: If expenses are from different plan years, funds will be depleted form the older plan year first (2) Requests for the current plan year must be received by BBP Admin by the Runout date of our plan (3) claims can be submitted online at https://betterbusinessplanning.wealthcareportal.com, email claims@bbpadmin.com, faxed or mailed to our office (4) Listed Over-the-Counter drugs are to treat a medical condition with Letter of Medical Necessity, (5) Documentation must include ALL of the following: Date of Service, Patient Name, Provider Name, Type of Service, and Cost of Service.

X____ ______________________

Plan Participant's Signature (You must sign this form to be reimbursed.) DATE

Claim Confirmation: You can easily view your claim status 24/7/365 by logging into the Participant Portal at https://betterbusinessplanning.wealthcareportal.com. Please allow 24-72 business hours for claims to be processed.