Health Care Spending Account Claim Form

(Do not fax or mail this instruction page.)

This form is used to request reimbursement for health care expenses only that are not reimbursed or reimbursable from other sources (e.g., health plan). Please note the following instructions:

- Use this form to request reimbursement of expenses incurred during the plan year.
- If you are submitting expenses for more than one plan year, submit a separate claim form for each plan year that you are an eligible active participant.
- You must submit copies of supporting documentation for each expense.
- You can be reimbursed only for services that have been received.

Option 1: *Go Paperless!*

You won't need to complete paper forms anymore. To submit claims online log on to **mylacountybenefits.com**, click on the "Spending Account" tile to be navigated to your account and then click on "File a Claim".

Option 2: Submit your claim using this form.

If the claim was created online or you used your BenefitWallet Visa card, do not use this form. Please print and mail or fax the claim confirmation letter you recieved along with copies of your documentation.

Step 1: Complete the form

- Please print in capital letters with the letters centered in the boxes as shown:

A	B	C	D		1	2	3	4

- Complete a separate line for each individual expense.

Step 2: Attach Supporting Documentation

- See the "Types of Supporting Documentation" section on page 2 for a description of what is considered acceptable by the IRS.
- Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.
- Do **not** send original receipts or original supporting documentation.

Step 3: Certify

- Read Section 3, Self Certification, then sign and date the form. This is required to process your request.

Step 4: Submit

- Fax the form and supporting documentation to **877-841-1152**.
- Make sure that you fax the form and supporting documentation together. The form should be the first page of your fax.
- If you do not have supporting documentation for the services incurred, please have your provider complete Section 4 of this form.
- Alternatively, you may also mail copies of your claims to:

  BenefitWallet
  P.O. Box 18009, Suite A
  Norfolk, VA 23501

  To expedite processing, please send only one claim form and copies of your supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

Remember

- Keep a copy of the form and all original receipts for your records.

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Types of Supporting Documentation

- All documentation submitted to substantiate a claim must include the following information:
  - Name of the person who incurred the service or expense
  - Name and address of the provider or merchant
  - Date the service or expense was incurred
  - Detailed description of the service or expense
  - Amount charged for the service or expense
- An Explanation of Benefits (EOB) contains all of the required information and is an excellent form of documentation to substantiate the expense.
- Credit card receipts and canceled checks alone are not acceptable documentation.

Remember To:

- Use the same expense code on one line to show the total expense, when multiple expenses are on one receipt (e.g., several over the counter items).
- Use one line per expense for expenses belonging to different expense codes or are on different receipts.
- Use additional copies of page 3 if your expenses exceed the number of lines available.
- Print legibly and use capital letters.
- Ensure that your claim form is legible by using black ink.

Please Do Not

- Fill out the form using red or blue ink.
- Highlight receipts or any part of the form.
- Send original receipts.
- Staple receipts to the form.
- Write outside of the boxes provided.
- Submit the same claim more than once.
- Fax or mail the instruction page.
- Email the claim form to **documents@mylacountybenefits.com**.
- Upload your claim form on **mylacountybenefits.com**.

List of Expense Codes

Sections 2 and 5 of the form need to specify the type of expense using one of the following:

Medical
101 = Ambulance
102 = Co-Insurance
103 = Deductible
104 = Doctor Visit
105 = Equipment
106 = Hospital
107 = Laboratory
108 = Pharmacy Prescription
109 = Related Travel
110 = Therapy

Medical – Over the Counter (OTC)
111 = OTC Medication

Medical – Preventative
201 = Immunization
202 = Physicals
203 = Screening
204 = Smoking Cessation
205 = Weight Loss

Dental
301 = Equipment
302 = Examination
303 = Orthodontia
304 = OTC Medication
305 = Pharmacy Prescription
306 = Treatment

Vision
401 = Equipment
402 = Examination
403 = OTC Medication
404 = Pharmacy Prescription
405 = Treatment

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Claim Filing Options:

File Claim Online: Go Paperless! You won't need to complete paper forms anymore. To submit claims online log on to **mylacountybenefits.com**, click on the "Spending Account" tile to be navigated to your account and click on "File a Claim".

Fax To: 877-841-1152

Mail To: BenefitWallet, P.O. Box 18009, Suite A, Norfolk, VA 23501

Questions? Contact us at 866-225-0067. Representatives are available from 7 a.m. to 7 p.m. PT, Monday - Friday.

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS.)

LAST FOUR DIGITS OF SSN

MAILING ZIP CODE

EMPLOYER NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS.)

EXPENSE 1 CODE (See page 2.)

PROVIDER NAME

SERVICE PROVIDED TO (NAME & RELATIONSHIP)

DATE OF SERVICE FROM (MMDDYY)	TO (MMDDYY)	AMOUNT	CLAIM # IF FILED ONLINE/VISA CARD
		$.	
		$.	
		$.	

SECTION 3: SELF CERTIFICATION

I certify that these expenses have been incurred by me or another person eligible under my reimbursement or spending account plan. The expenses are eligible expenses as defined by the IRS and have not been previously reimbursed nor am I seeking reimbursement for these expenses from any other source. I understand that BenefitWallet, its agents, or employees, will not be held liable if I submit ineligible expenses for reimbursement. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify BenefitWallet. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

EMPLOYEE SIGNATURE:* ______________________ DATE: ____________

*Your signature is required in order to process your claim for reimbursement.

SECTION 4: PROVIDER CERTIFICATION

I, ______________________, certify the information provided on this form is accurate and I, or someone within my group, have provided the services specified to the individual(s) on the dates indicated above. I certify the services provided are required to treat or mitigate a specific medical condition. I understand the purpose of my signature on this form is to provide third party substantiation for the services rendered and eliminate the need for the Account Holder to provide additional supporting documentation required for reimbursement purposes.

PROVIDER SIGNATURE: ______________________ SIGNATURE DATE: ____________

DO NOT SEND ORIGINAL RECEIPTS

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