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**For Limited Health Care FSA Claims**

- Only dental, orthodontic, vision and preventive care expenses not covered by the insurance company are eligible for reimbursement.
- Eligible over-the-counter medicine and items are limited to those related to dental, vision or preventive care (e.g. denture adhesive, toothache relief, contact lenses solution, lubricant eye drops, home diagnostic kits).

**INSTRUCTIONS:**

- 1 - **Complete ALL SECTIONS** of this form to ensure timely payment.
- 2 - **Submit the following documentation with this claim form:**
  - a. The receipt, explanation of benefit (EOB), or invoice for the services rendered containing all of the following information:
    - i. The name of the person(s) for whom services were rendered and their relationship to you
    - ii. The provider's name and address
    - iii. The date range of the services rendered
    - iv. A detailed description of the services
    - v. The amount due/paid
- 3 - **NOTE:**
  - a. Cancelled checks, credit card receipts, or balance due statements are **NOT** sufficient.
  - b. If submitting prescriptions, please provide us a copy of the drug tag or pharmacy ledger.
  - c. If you do not have insurance coverage for expenses submitted, you may select the option on your claim form indicating no coverage.
- 4 - **IMPORTANT: STARTING JANUARY 1, 2011, ANY OVER THE COUNTER (OTC) MEDICATION PURCHASED WILL REQUIRE A PRESCRIPTION FROM YOUR PHYSICIAN IN ORDER TO BE REIMBURSED.**
- 5 - You may send claims via any one of the following options: fax, e-mail, postal mail, or by logging onto your account at [www.proviewbenefits.com/login/](http://www.proviewbenefits.com/login/). If faxing your claim, please indicate the number of pages included. Faxed claims must be legible for processing. # OF FAXED PAGES = \_\_\_\_\_. If sending claims via e-mail, note that there is a 3MB size limit to e-mail attachments.

**PART A: YOUR INFORMATION**

EMPLOYER NAME			
EMPLOYEE NAME (First, Middle, Last)			SOCIAL SECURITY NUMBER (optional)
STREET ADDRESS		CITY	STATE ZIP
<input type="checkbox"/> NEW ADDRESS			
DAYTIME PHONE NUMBER (with area code) ( ) -	EVENING PHONE NUMBER (with area code) ( ) -	E-MAIL ADDRESS	

**PART B: REIMBURSEMENT REQUEST**

DATE(S) OF SERVICES RECEIVED (list date range) *You may use one form for all health care expenses.	
AMOUNT TO BE CONSIDERED UNDER THE HEALTH CARE FSA ACCOUNT (GRAND TOTAL)	\$

Claims **MUST** be received by 12 Noon (PST) Wednesday to be considered for reimbursement on Friday.

**PART C: EMPLOYEE STATEMENT**

I certify that the expenses for which reimbursement is claimed from the Flexible Spending Account have been incurred by me, or by my eligible dependents. I further certify that these expenses have not been paid or payable by any other health plan coverage, including a Health Savings Account (HSA). I also certify that I have not, and will not, claim a tax deduction or credit these expenses on my federal, state, or local tax returns in violation of state or local law.

Participant Signature

Date