ProView™
www.proviewbenefits.com

HEALTH CARE FSA REIMBURSEMENT CLAIM FORM

ATTN: FSA Department
P.O. Box 5689
Irvine, CA 92616
Phone: 888.289.4062 • Fax: 800.930.0437
Email: fsa@proviewbenefits.com
Website: www.proviewbenefits.com

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/. 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.

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).

PART A: YOUR INFORMATION

EMPLOYER NAME			
EMPLOYEE NAME (First, Middle, Last)		SOCIAL SECURITY NUMBER (optional)	
STREET ADDRESS	CITY	STATE	ZIP
☐ 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