



ACCOUNT RULES AND CLAIM FILING INSTRUCTIONS

Direct Deposit Authorization

Please circle if this is a new account or a change in banking.

New Change Cancel Month Day Year

Account Number (Include hyphens, but not spaces and/or special symbols)

Routing Transit Number

(All 9 boxes must be filled. The first two numbers must be either 01 through 12 or 21 through 32.)

Joan Doe
Anywhere, USA

PAY TO THE ORDER OF _____ \$ _____
DOLLARS

YOUR TOWN BANK
YOUR TOWN, AR 123456

FOR _____
%25550005% 123456789022 †

VOID

EMPLOYEE SIGNATURE: _____

DATE: _____

INSTRUCTIONS

- Complete ALL information on the form for each amount claimed for reimbursement. Incomplete forms cannot be processed (this includes for lack of SSN and Direct Deposit Information).
- Attached copies of required documentation to the claim (See Required Documentation below for information).
- Sign and date the claim.
- Make a photocopy of the claim for your records.
- Submit the claim and required documentation via fax, email, mail or through our website. *Please limit faxed claims to 9 pages or less.*

REQUIRED DOCUMENTATION

- ✓ Medical procedures (including doctor visits, labs, surgery, etc.) and Dental procedures: Please submit an itemized statement or an Explanation of Benefits (EOB) from the insurance carrier that reflects the date of service, services rendered, total cost of procedure, total insurance coverage and total patient responsibility. An EOB is required for any expense other than a co-pay. If the expense is not covered by insurance, you may submit an itemized statement that includes name of the patient and provider, date of service, type of service/supply, and charge. *Balance forward, previous balance, credit card receipts, canceled checks or account statements are not sufficient documentation.*
- ✓ Prescriptions: Submit a copy of the pharmacy Rx label or receipt which includes the service date, patient name, name of prescription, and amount.
- ✓ Over-the-Counter Items: Submit a copy of the cash register receipt which includes the place and date of purchase, items purchased and cost of purchase. If items listed on receipt are not obvious for identification purposes, please *handwrite* a detailed description or include a copy of the container the item came in.
- ✓ Orthodontia: Approximately one-third of the total cost can be reimbursed up front, as it can be attributed to the molds, application of appliances, etc. Afterward, reimbursements will be released monthly throughout the duration of the treatment plan as services are incurred. In order to be reimbursed for orthodontic expenses, you must provide a copy of the orthodontic contract, along with an EOB if insurance is covering any portion of the treatment.
- ✓ Massage Therapy, Supplements, Vitamins or expenses not covered by insurance but may be required for a specific medical/dental condition: Submit a letter from your physician stating a specific condition has been diagnosed and that this service or supply is medically necessary for the treatment of that condition.



P.O. Box 867599, Plano, TX 75086 Phone: (817) 731-6258
 Fax: (817) 731-9029 Email: claims@abybenefits.com Website: www.abybenefits.com

REIMBURSEMENT REQUEST FORM

NAME _____ EMPLOYER _____ SSN _____ - _____ - _____

HOME (MAILING) ADDRESS _____ CITY _____ STATE _____ ZIP _____

check here if your address has recently changed

EMAIL ADDRESS _____ @ _____ DAY PHONE (_____) _____ - _____ (optional)

What account is this for? Please circle		HRA Parking & Transit	FSA Medical FSA Dependent Care	Is your proof of expense attached? Yes No		
SUMMARY OF EXPENSES				Dates of Service		Payment
Name of Individual Receiving Services	Relationship to Employee	Provider Tax ID or SSN (Dependent Care Claims ONLY)	Nature of Expense	From MM/DD/YY	To MM/DD/YY	Employee Responsibility check if MySource card used
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
❖ An EOB is required for any expenses other than a co-pay. Claims must be filled out completely and received by 12pm prior to the processing day in order to obtain reimbursement during the next processing cycle.					TOTAL	

I (above named Participant) understand and agree that:

- These expenses are not reimbursable from any other health plan, insurance or other source, and will not be used to claim any federal income tax deduction or credit.
- The Unreimbursed Medical expenses listed above would be deductible medical expenses under Internal Revenue Code Section 213 and are allowed under Prop. Treas. Reg. 1.125-2;
- If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent under the plan as defined in Code Section 152;
- By submitting this information (via fax, e-mail, or any other media), I am responsible for any inappropriate use or disclosure that may occur due to incorrect or inaccurate transmissions;
- I authorize the Plan and its service provider, their respective agents, employees, sub-contractors and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan Administration purposes such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation;
- I authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud;
- I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above; and
- This authorization does not in any way limit any right that ER/PSP, their respective agents, employees, sub-contractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.