



## Medical Expense Recovery Form Instructions

**The form should be completed and signed by the Employee who established the Flexible Spending Account with the Employer listed in the first section on page 1.**

- Enter your name, Employee ID Number (last 4 digits of your Social Security Number), and your email address.
- For each expense the following information is required:
  - List each date of service on a separate line (no date ranges please).
  - List the patient(s) name(s) and relationship(s) to you (the employee). Reimbursement requests for multiple family members may be submitted on the same form. Use separate lines for each patient.
  - List the name(s) of the provider(s). Indicate the grand total requested for reimbursement.
- If you need additional space for extra dates of services, please use an additional form or you may use a spreadsheet. If using a spreadsheet, all required information must be included and that spreadsheet must accompany a signed form. Spreadsheets without an accompanying form will not be accepted.
- Read the certifications carefully to make sure you understand your responsibilities and accountability.
- **The Employee's signature is required**, as indicated by the bold arrow. Please date the form as well in the space provided.

- **Substantiating documentation must accompany the form** (e.g., explanation of benefits (EOBs), itemized receipts, etc.). Itemized receipts need to include:

- Patient name (name of person who incurred the service or expense)
- Name and address of the provider or merchant
- Date of service for the amount charged
- Description of service
- Amount due for the service

Receipts for over-the-counter (OTC) items do not need to include the person's name, but the receipt must display the name of the item (e.g., bandages).



A sample receipt from 'Local Pharmacy' at 12 Main Ave, Mytown, NY 12345, (800) 555-1234. The receipt includes a star icon next to the pharmacy name, a star icon next to the date '08/01/17', a star icon next to the patient name 'JOHN DOE (518) 555-9876' and Rx number '1234567-12345', a star icon next to the medication name 'AMOXICILLIN 500MG CAPSULES' and quantity 'QTY: 90 0 Refill', and a star icon next to the amount '\$8.00' which is enclosed in a blue box.

- Submit the form and substantiation to Benetech via:
  - **US mail** -- to the address at the top of the page; or,
  - **Fax** – to 518.283.2384; or,
  - **Email** – to [flexinfo@benetechadvantage.com](mailto:flexinfo@benetechadvantage.com)