REIMBURSEMENT CLAIM FORM

EMPLOYER:			
NAME:	LAST FIRST MI	SS#:	
ADDRESS:	STREET CITY STATE ZIP	PHONE :	( )
EMAIL:			

☐ PLEASE CHECK IF YOUR NAME OR ADDRESS HAS CHANGED. ☐ PLEASE CHECK IF YOU ARE OFFSETTING AN INELIGIBLE DEBIT CARD TRANSACTION.

MEDICAL EXPENSE CLAIMS						
CIRCLE FSA, HRA, OR LP FSA	DID YOU USE YOUR MCGREGOR CARD?	DATE(S) OF SERVICE MM/DD/YY	SERVICE RECIPIENT NAME	DESCRIPTION OF SERVICE	PAY CLAIM TO PROVIDER?	CLAIM AMOUNT
FSA HRA LP FSA	Y / N				☐	$
FSA HRA LP FSA	Y / N				☐	$
FSA HRA LP FSA	Y / N				☐	$
FSA HRA LP FSA	Y / N				☐	$
FSA HRA LP FSA	Y / N				☐	$
FSA HRA LP FSA	Y / N				☐	$
FSA HRA LP FSA	Y / N				☐	$
FSA HRA LP FSA	Y / N				☐	$
				TOTALS:		$

PROVIDER ADDRESS (IF APPLICABLE)

PROVIDER NAME: ______________________________

STREET: ______________________________

CITY: ______________________ ST: ________ ZIP: ____________

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I CERTIFY THAT THE EXPENSES FOR REIMBURSEMENT REQUESTED FROM MY ACCOUNTS WERE INCURRED BY ME (AND/OR MY SPOUSE AND/OR ELIGIBLE DEPENDENTS), WERE NOT REIMBURSED BY ANY OTHER PLAN, HAVE NOT BEEN SUBMITTED FOR REIMBURSEMENT PREVIOUSLY, AND, TO THE BEST OF MY KNOWLEDGE AND BELIEF, ARE ELIGIBLE FOR REIMBURSEMENT UNDER MY REIMBURSEMENT PLANS. I (OR WE) WILL **NOT** USE THE EXPENSE REIMBURSED THROUGH THIS ACCOUNT AS DEDUCTIONS OR CREDITS WHEN FILING MY (OUR) INDIVIDUAL INCOME TAX RETURN.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, ADMINISTRATOR, OR PLAN SERVICE PROVIDER, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE: ______________________________ **DATE:** ______ /______/______

SUBMIT BY:

ONLINE	MOBILE APP	EMAIL	FAX
WWW.MCGREGOREBA.COM	"MCGREGOR MOBILE"	FLEX@MCGREGOREBA.COM	(877) 224 -3539

Claim Filing Instructions

This claim form is only required for Email, Fax, or Mail submissions.

Filing Online or via Mobile App does not require this form.

1. **Print the Header information:** Be sure to indicate your Employer's name. Please indicate if your name or address has changed. If you are submitting paid bill to offset a previously denied claims, check the box.

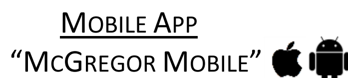
2. **List expenses:**
   - You cannot submit a claim for a service period that begins in one plan year and ends in the next plan year. File two reimbursement claims, one for each plan year.
   - If you have multiple benefit plans, please circle the account you are filing for:
     - **FSA –** Flexible Spending Account
     - **HRA –** Health Reimbursement Arrangement
     - **LP FSA** – Limited Purpose FSA (special Vison/Dental only plans)

3. **Attach required documentation:** If you have several statements, please include them in the same order as they are listed. Claims from the same provider may be subtotaled as one line-item.
   - **Any receipt must include:**
     - The name of the medical service provider;
     - The date or range of dates of service for the medical care or day care provided. Although this date may be the same as the date paid, it must be clear on what date the service was provided.
       - **IMPORTANT:** Please refer to your HR department, the benefit Summary Plan Description (SPD), or call our office for specific restrictions on claim submission deadlines.
     - A description of the service provided (for example, doctor's office visit or prescription);
     - The name of the person or persons receiving the medical care; and
     - The cost of the service, not just the amount paid.
       - *CREDIT CARD/DEBIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ALLOWED DOCUMENTS PER IRS REGULATIONS.*
   - **Explanations of Benefits (EOB)** are provided by your insurance provider and have all the details required by McGregor. Some plans require EOBs to be submitted prior to reimbursement.
   - Requests submitted without adequate claims documentation cannot be processed and will be returned.

4. **Sign and submit** the claim form
   - **Keep** copies for your tax records.

Orthodontics: Requests may be reimbursed for a reasonable monthly payment on or after the payment is due and paid. The payment must be a reasonable approximation of the value of each month's service. You may only file claims for orthodontic payments while treatment is in process. You must submit a paid receipt from your orthodontist or a photocopy of the monthly payment coupon. Pre-payments are not allowed.

997 Governors Lane
Suite 175
Lexington, KY 40513

ONLINE	MOBILE APP	EMAIL	FAX
WWW.MCGREGOREBA.COM	"MCGREGOR MOBILE" 	FLEX@MCGREGOREBA.COM	(877) 224 -3539