CHP
Consolidated Health Plans

FSA Reimbursement Form

(See instructions on reverse side)

FSA= Medical Flexible Spending Account

_____ Employee's Name (Last, First, MI)

XXX-XX-_____ Last 4 digits of SSN

Lower Pioneer Valley Educational Collaborative (LPVEC) Group Name

_____ Address

_____ City _____ State _____ Zip Code _____ Daytime Phone #

_____ E-mail Address

☐ Check here if this is a new mailing address

MEDICAL CARE EXPENSES (FSA)- MUST BE COMPLETED (see instructions on reverse)

Patient's Name	Service Date	Type of Service (i.e. co-pays, deductibles, coinsurance, member responsibility)	Provider Name	Do you have other coverage for this service? (attach EOB)	Amount of Expense to be Reimbursed
				NO	
				NO	
				NO	
				NO	
				NO	
				NO	

Total reimbursement requested	$

I hereby certify that:

- **The information given on this reimbursement form is complete and correct.**
- **I have not received reimbursement for these expenses from the reimbursement account or from any other source.**
- **All medical care expenses listed above comply with requirements and guidelines listed on page 2 of this form.**

This authorizes my insurance company, prepayment organization, employer, hospital, physician or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

X_____ _____/_____/_____

Employee Signature (If submitted without signature claim(s) will be denied) **Date**

Mail your completed form and required documentation to:
Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, MA 01104 or Fax to 413-733-4612
or email to: flexclaim@chpemail.com
Telephone 413-733-4540 ● Toll Free 800-633-7867 ● www.consolidatedhealthplan.com

Instructions:

1. Complete Employee Information section (please print).
2. Complete Health Care Expense section as appropriate. Service must be incurred before being reimbursed.
3. Attach all require supporting documentation.

   Supporting Documentation: The type of documentation described under either A or B below **must** be attached to the completed form.

   A. Explanation of Benefits form (EOB): The is the form you receive each time you or a health care provider submit claims for payment to your health, dental or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental or vision care plans, you **must** attach an EOB.

   B. All other expenses: For expenses not covered at all by your (or your spouse's) health, dental or vision care plans, reimbursement request **will not be processed** without acceptable evidence of your expenses. A canceled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain the following information:
      - Name of person for whom the service/supply was provided
      - Date expense was incurred
      - Type of service (i.e., copay, deductible, coinsurance, dental, vision, RX, over the counter drugs)
      - Name of provider (i.e., physician, hospital, dentist, pharmacy)
      - Amount of expense(s)

4. **Sign and date the form (If submitted without employee signature, claim(s) will be denied).**
5. Please make copies for your records, as these documents will not be returned.
6. Mail the completed form and attachment(s) to: **Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, MA 01104 or fax to (413) 733-4612 or email to flexclaim@chpemail.com.**
7. If you have any questions regarding your reimbursement account or claims, please call 1-800-633-7867.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Medical care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this plan.
- Reimbursement will be only made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.