PacificSource ADMINISTRATORS

# Request for Reimbursement from FSA or HRA Form

## Instructions

Please complete all information on the reverse and follow the instructions below. This form is used to request reimbursement for eligible healthcare and dependent care expenses. One form may be used for multiple expenses. Claims may be submitted electronically through our FSA/HRA portal at PSA.PacificSource.com or by mail or fax. Only one method of requesting reimbursement is necessary. If you have a question or would like assistance completing this form, please call us at (541) 485-7488 or (800) 422-7038 and we will be happy to assist you.

For a list of eligible expenses, please see the appropriate Examples of Eligible Expenses on our Forms and Fliers page at PSA.PacificSource.com/forms.

**Healthcare Expenses** for FSA or HRA

1. After completing the Request for Reimbursement Form, attach a copy of your insurance company's Explanation of Benefits (EOB) or bills/account histories for the services you have received. Submitted documentation must include:
   a. the date the service was incurred (not necessarily equal to the date of payment)
   b. a brief description of the service or product
   c. the amount paid for the service
   d. the patient responsibility (the amount you owed to the provider or merchant) for the service or product after the insurance has paid (if insurance was billed)
2. If a service has been partially covered by insurance, send a copy of the EOB received from the insurance company. Request only the amount you will actually be paying for a service. PacificSource Administrators cannot reimburse you for amounts that will be paid by insurance.
3. Third party verification is required; therefore, cancelled checks and/or check copies may not be used as documentation.
4. Please retain originals of the bills/forms submitted for your personal tax records. We store documents electronically and destroy the originals after processing; therefore, originals will not be returned to you. Incomplete Reimbursement Request Forms or those received without proper documentation attached cannot be processed. If this happens, you will receive a letter or explanation.
5. In certain instances, statements from your healthcare provider may be necessary to verify the medical necessity of the procedure or prescription. Please call if you have questions.

**Dependent Care Expenses**

6. Please include your dependent's full name and date of birth on the Request for Reimbursement form.
7. After completing the Request for Reimbursement Form, attach a copy of the bill showing the provider's name, dates of service, and the amount you are responsible for paying. Childcare expenses may be submitted for children up to the age of 13.
8. Third party verification is required; therefore, cancelled checks and/or check copies may not be used as documentation. If your daycare provider does not provide documentation, they must sign this form each time you submit a claim. (Photocopied signatures are not accepted.) In certain instances, statements from your healthcare provider may be necessary to verify the medical necessity of adult daycare. Please call if you have questions.
9. Please obtain originals of the bills/forms submitted for your personal tax records. Refer to #4 above for more information.

**Please send the completed form to** PacificSource Administrators, PO Box 2797, Portland, OR 97208; (541) 485-7488, (800) 422-7038; fax (866) 446-6090

*Continued on reverse >*

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# Request for Reimbursement from FSA or HRA Form

## Employee

Employer _____ PSA Member ID _____

Employee Last Name _____ First Name _____ MI ___

Mailing Address _____ ☐ Check if address is new

City _____ State _____ ZIP _____

Primary Phone _____ Secondary Phone _____

Email _____

## Healthcare Expenses (for those not charged to your benefit debit card)

Per IRS guidelines, please attach appropriate documentation (explained on the reverse). One form may be used for multiple expenses. Do not send original documentation. If you are enrolled in both health FSA and HRA and would like to be reimbursed automatically per your plan specifications, check both FSA and HRA. Selecting both is the default.

| FSA | HRA | SPA | Service Date | Amount | Description |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | _____ | $ _____ | _____ |
| ☐ | ☐ | ☐ | _____ | $ _____ | _____ |
| ☐ | ☐ | ☐ | _____ | $ _____ | _____ |
| ☐ | ☐ | ☐ | _____ | $ _____ | _____ |
| ☐ | ☐ | ☐ | _____ | $ _____ | _____ |

Total reimbursement (add amounts) $ _____

If you have an expense that you expressly do not want run through both plans, indicate either FSA or HRA. Many HRAs only allow prescriptions to be paid if they apply toward your deductible. Please send an Explanation of Benefits (EOB) for each prescription. If you would like the prescription to pay from your FSA because you already know that it is not eligible for the HRA, select the FSA checkbox.

## Dependent Care Expenses (childcare and/or preschool up to age 13, adult daycare for dependents)

| Dependent Name | Date of Birth | Service Dates | Amount | Provider's Signature (see reverse for requirements) |
|---|---|---|---|---|
| _____ | _____ | _____ | $ _____ | _____ |
| _____ | _____ | _____ | $ _____ | _____ |
| _____ | _____ | _____ | $ _____ | _____ |

Total reimbursement (add amounts) $ _____

## Authorization

To the best of my knowledge, my statements on this form are complete and true. I am claiming reimbursement only for eligible expenses incurred for eligible plan participants during the applicable plan year. I certify that these expenses have not been, nor are they expected to be, reimbursed under this or any other benefit plan, and will not be claimed as income tax deduction. I have read and understand the information provided on the reverse of this form. I authorize my flexible spending account or health reimbursement arrangement to be reduced by the amount requested above.

Employee Signature _____ Date _____

**Please send the completed form to** PacificSource Administrators, PO Box 2797, Portland, OR 97208; (541) 485-7488, (800) 422-7038; fax (866) 446-6090