

# Healthcare Flexible Spending Account Reimbursement Form

## How to file a claim:

**Online:** The fastest way to receive reimbursement for your completed claim is through the web or MyChoice Mobile App. Reimbursement for completed claims submitted via web or mobile app is processed within 2 – 3 business days.

**Via email, mail or fax:** Fill out your form electronically and submit via email, fax, or mail. Completed claims submitted via email, mail or fax may take up to 7 – 10 business days to process.

- **Email:** [claims@mychoiceaccounts.com](mailto:claims@mychoiceaccounts.com)
- **Mail:** MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax:** 855-883-8542

## Instructions for filling out this form:

This form is available for only the Healthcare Flexible Spending Account and cannot be used for expenses incurred with a Health Savings Account. For more information on how to submit a Health Savings Account reimbursement request, please visit us at [www.businesssolver.com/mychoice-accounts/participants/health-savings-account](http://www.businesssolver.com/mychoice-accounts/participants/health-savings-account).

Complete each section completely.

If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

**A** SERVICE TYPE (indicate the type of expense that is being claimed for reimbursement)

**B** START AND END DATE OF CLAIM

**C** AMOUNT SUBMITTED FOR CLAIM

<b>SECTION 1: YOUR INFORMATION</b>	
<input type="radio"/> MEMBER SOCIAL SECURITY NO. or <input type="radio"/> EMPLOYEE ID (Required, No Dashes)	
1 2 3 4 5 6 7 8 9	
MEMBER LAST NAME (Required)	
S M I T H	
MEMBER EMAIL	
SSMITH@ACME.ORG	
MEMBER TELEPHONE NUMBER	
4 9 0 1 0 5 5 6 8 7	
<b>SECTION 2: YOUR EXPENSES</b>	
<b>A</b> SERVICE TYPE	<b>B</b> SERVICE START DATE (MM/DD/YY)
<input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	0 2 0 1 2 2
<input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> OTHER	0 2 2 1 2 2
PATIENT NAME	<b>C</b> AMOUNT
SUSAN SMITH	\$ <input type="text"/> 3 2 3 . 1 9

## Submitting a completed claim:

To ensure your claim is complete, and can be processed as quickly as possible, provide all information as required in Your Information section, and all necessary information as required for a claim being submitted for your eligible dependent(s). **If any of the required documentation or information is missing, your claim will not be complete and may be delayed in processing.**

Below are 5 pieces of information which must be included in the documentation submitted with your claim:

1. Name of the member (or eligible dependent) whom incurred the expense
2. Date the expense was incurred (not the date paid)
3. Name of service provider or carrier name
4. Description of the service and/or expense
5. Amount of the expense

If you have questions on what expenses are eligible for reimbursement under the Healthcare Flexible Spending Account, please reference IRS Publication 502.

**Please note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.**

