PIOPAC Fidelity
Third Party Administration
"Security, Integrity, Trust"

Request for Reimbursement

☐FSA ☐ HRA☐ Debit Card Substantiation

Plan will pay Flexible Spending Account (FSA) before Health Reimbursement Account (HRA)

Participant name (*Please type or print*)**:** _____ **Social Security #:** _____

Participant Address (*complete only if **new***): _____

City State Zip

Employer _____

Daytime Phone: _____ **E-mail:** _____

By submitting this claim form I request reimbursement from my Flexible Spending Account(s) as listed below. I agree to the Terms and Conditions stated below; I certify and warrant to PIOPAC Fidelity that these are eligible medical and/or dependent day care expenses that I or my dependents have incurred. (Please read reverse side for instructions.)

=>Participant Signature: _____ **Date**: _____

Dependent/Child Care

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

Name of Dependent (A)	Age	Provider Name (B)	Dates Service Provided (C)	Requested Amount of Reimbursement (D)	PIOPAC Use Only

Please attach a receipt or itemized bill listing (A), (B), (C) and (D) or have provider certify below. Cancelled checks or bills showing a payment or previous balance only are not acceptable.

Provider's Certification/Verification

I certify that the above-described dependent care expenses were incurred by the Participant named above.

_____

Business/Provider Signature Address Date

Unreimbursed Medical

LIST EACH RECEIPT SEPARATELY (Use additional forms if necessary.)

Patient Name (A)	Provider Name (B)	Description of Service (C)	Dates Service Provided (D)	Requested Amount of Reimbursement (E)	PIOPAC Use Only

Please attach a third-party receipt, itemized bill or Explanation of Benefits (EOB) listing (A), (B), (C), (D) and (E) or have provider certify below. Cancelled checks or bills showing a previous balance or balance due only are not acceptable.

Provider's Certification/Verification

I certify that the above-described unreimbursed medical expenses were incurred by the Participant named above.

_____

Medical Provider Signature Address Date

TERMS and CONDITIONS

I (above named Participant) understand and agree that:

- medical expenses must qualify as deductible expenses under Internal Revenue Code Section 213(d) and allowed under Prop. Treas. Reg.1.125.2, and cannot be reimbursed by any other source or used as a deduction or credit on my personal income tax return(s).
- dependent care expenses must qualify for the dependent care tax credit and that I cannot claim the tax credit for expenses submitted hereunder.
- the taxpayer identification (Social Security) numbers of any dependent care service provider(s) will be supplied to the IRS on my annual tax return(s) using Form 2441.
- I am responsible for inappropriate use or disclosure of my information that occurs due to my selected method of transmitting this information (e.g. fax, e-mail, or any other media).
- I hereby authorize the Plan and its service provider (PIOPAC), and their respective agents, employees, sub-contractors, and assigns to use the information provided above to administer the Plan (including the eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation and to further disclose and all such information as is reasonably required for such purposes.
- I further authorize any provider, insurer or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud.
- I hereby expressly waive and release any claims related to the use, disclosure, or release of information so long as the information is used in furtherance of administering the Plan (including the processing or evaluating my claim for benefits under the Plan) or detecting or preventing fraud.
- This authorization does not and is not intended to in any way limit any right the Plan, PIOPAC, or their respective agents, employees, subcontractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

How to File a Request for Reimbursement

1. Complete the front side of this form, being sure to **sign** and **date** it. Failure to complete **all** areas can result in a delay in processing and claim reimbursement. **Note**: All fields must be filled in completely, do not indicate, "See attached" in any field.
2. **Do not** submit **Dependent Care** (DDC) or **Unreimbursed Medical** (URM) claims until **after** services are rendered. Verify that the services received are eligible expenses. See below and/or refer to your *Participant Guide to Flexible Spending Accounts.*
3. Attach legible itemized bills, receipts or Explanation of Benefits (EOB's) which show:
   - The **name** of person(s) receiving service
   - The **name** of provider(s)
   - The **date(s)** of service
   - The **charges** for each service
   - A **description** of service or supplies furnished

   Note: Drug receipts must clearly show the drug name. Balance due statement and credit card receipts are not valid receipts unless it indicates all of the required information listed above. Never send in receipts without a completed Request for Reimbursement form.
4. The business/provider may sign this form in lieu of attaching a receipt.
5. If you carry group insurance, first submit expenses to the insurance carrier. Attach the Explanation of Benefits (EOB) to document any reimbursement or credit to your deductible or coinsurance amounts.
6. Any reimbursements under $15 will not be released, unless it is the final balance of your election.
7. **Please make a copy for your files.**

General IRS Eligibility Guidelines

To qualify for reimbursement from Flexible Spending accounts, expenses must be incurred during ***your*** Plan Year for which you are requesting reimbursement.

1. **Unreimbursed Medical Account** - can be used for medical expenses for you or your family that are not covered by any other health plan. Items covered include, but are not limited to:
   - major medical co-payments and deductibles (excluding insurance premiums of any kind)
   - certain medical, dental, hearing & vision services (excluding cosmetic procedures)
   - most prescribed drugs, contraceptives, insulin and smoking cessation programs (herbal drugs and over-the-counter drugs may be eligible, if permitted by the Plan and used to treat a medical condition)
   - purchase and rental of most medical devices, including diabetic-related supplies
   - most medical assistance tools for disabilities, such as seeing-eye dogs and text telephone for hearing impairments
2. **Dependent/Child Care Account** - reimbursement for care of your child or other tax dependent while you are at work. For reimbursement services at a dependent care center, the center must comply with all state and local laws.

   Specifications for this account are:
   - your child must be age 12 or under and resides with you
   - your child or other dependent over the age of 12 must be incapable of self support and spend eight hours or more a day in your home
   - the individual caring for your child (age 12 and under or other dependent) must not be your tax dependent
   - reimbursement cannot exceed $5,000 annually ($2,500 if married filing separate returns) or the earned income of you or your spouse, which ever is less

TO SUBMIT YOUR COMPLETED FORM:

FAX completed Request for Reimbursement forms to: **(808) 536-0430**

NOTE: Use discretion when faxing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to PIOPAC.

OR

MAIL completed request for reimbursement forms to**:**

PIOPAC Fidelity
FSA Claims Dept.
1132 Bishop Street Suite 2101
Honolulu, HI 96813

EMAIL form to FSAClaims@piopac.com

NOTE: To speed up the process of your claim, please attach all receipts to a full 8x10 sheet of paper.

For Customer Service call: (808) 792-5226

Employer: ______________________ **Date:** ______________________

Name: ______________________ **SSN:** ______________________

Line #	Patient	Provider Name	Description of Service	Date of Service	Requested Amount	PIOPAC Use only