Flexible Spending Account Reimbursement Request Form

Submit your completed form and all claim documentation (Include copies of ALL receipts and documentation) to Benefit Coordinators Corporation (BCC):

For the fastest reimbursement and trackable progress, submit your claims through My SmartCare:
My SmartCare Mobile App
My SmartCare Online Portal: www.mywealthcareonline.com/bccsmartcare

Additional submission methods:
Mail: Benefit Coordinators Corporation, Attn: FSA
Two Robinson Plaza, Ste. 200, Pittsburgh, PA 15205

Fax: 412-276-7185

E-Mail: fsa-claims@benxcel.com
PDF files only, attachment cannot exceed 5MB

Download: https://secure.benxcel.com

For detailed reimbursement submission instructions, visit www.benxcel.com and view "Submit Health Care Claim" and "Submit Dependent Care Claim" in the Forms and Brochures section. If your request is missing any vital information, you will receive an Explanation of Benefits (EOB) denying your request with an explanation of the additional information needed to complete the reimbursement. It's imperative that you sign the reimbursement form to avoid a denied request.

EMPLOYER:	**GROUP NUMBER:** BB1055	
EMPLOYEE NAME:		**LAST 4 DIGITS OF SSN:**
EMPLOYEE ADDRESS: ☐ *Please check if this is a change in address since you last submitted a claim.*		**NUMBER OF PAGES** (including receipts):
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP:**
E-MAIL ADDRESS:	**FAX NUMBER** (return correspondence)**:**	
HOME PHONE:	**WORK PHONE:**	

IRS HEALTH CARE ACCOUNT EXPENSES: If a health care charge is eligible for full or partial reimbursement from an insurance carrier, the charge must be submitted to all applicable insurance carriers before this Plan can make payment. Once the claim has been processed the insurance carrier, attach your Explanation of Benefits statement (EOB) with an itemized receipt. If the charge does not need to be submitted to the insurance carrier (office visit copays, prescription copays, eligible over-the-counter drugs, etc.) attach your itemized receipt. Do not attach checks or credit card receipts, as the IRS does not recognize these as valid receipts for this program.

DATE OF SERVICE (MM/DD/YYYY)	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	RECIPIENT OF SERVICE	RELATIONSHIP TO EMPLOYEE	NET AMOUNT
					$
					$
					$
					$
					$
				TOTAL (required):	**$**

DEPENDENT CARE ACCOUNT EXPENSES (Attach a copy of the invoice and receipt. Provider's signature is required if there is not a receipt attached)

PROVIDER NAME:	**SS# / TIN#:**	
STREET ADDRESS		
CITY:	**STATE:**	**ZIP:**

DEPENDENT NAME	**DEPENDENT DATE OF BIRTH:**
Date(s) of Dependent Care Coverage:	
Total Claim:	**Provider Signature** (In lieu of receipt):_____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my Flexible Spending Account to be reduced by the amount requested.

EMPLOYEE SIGNATURE (Required) _____ DATE _____

Managing your reimbursement account has never been easier! For instant access to your account, register with My SmartCare's online portal at https://www.mywealthcareonline.com/bccsmartcare/ or download the free My SmartCare mobile app from your Apple or Android device.