# Medical Flexible Spending Account
# Claim Reimbursement Form

CO-1307 Revised 9/2018

Office of the State Comptroller
Healthcare Policy & Benefit Services Division

| EMPLOYEE NAME | SOCIAL SECURITY NUMBER | EMPLOYEE NUMBER | DAYTIME PHONE NO. |
|---|---|---|---|
| | - - | | |

| HOME ADDRESS (if not on file) | EMAIL ADDRESS (if not on file) |
|---|---|
| ( ☐ Check if new address) | |

MEDFLEX PRE-PAID BENEFITS CARD

If you've used your pre-paid benefits card to pay for MEDFLEX eligible expenses, check the box below and submit copies of expense receipts with this claim form. Sign and date this form and mail or fax to the address provided at the bottom of the form. The Claim Reimbursement Information section below does not need to be completed.

☐ I have used my pre-paid benefits card to pay for MEDFLEX eligible expenses and am attaching substantiating receipts.

CLAIM REIMBURSEMENT INFORMATION

If you have not used the MEDFLEX Pre-paid Benefits Card and are seeking eligible MEDFLEX claim reimbursements, complete the section below and attach substantiating receipts.

| Code Type | Expense Incurred Date | Name of Patient for whom expense was incurred | Relationship (spouse, child, tax dependent) | Provider of Service | CLAIM AMOUNT |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | TOTAL | $ |

I certify that the expenses for reimbursement requested from my MEDFLEX account were incurred by me, my spouse or tax-eligible dependent and are eligible for reimbursement under the Internal Revenue Code Section 105 and the State of Connecticut MEDFLEX plan document.

I certify that pursuant to IRS regulations, the expenses have not been submitted previously for reimbursement and have not and will not be reimbursed by any other plan, health insurance carrier or person.

I certify that the claim submitted is only for reimbursement of my MEDFLEX expenses and that the medical products and/or services were actually incurred during my plan year coverage period.

I certify that I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

I understand that over-the-counter drugs/medications, certain medical services and/or products may require additional certification from my health care practitioner that the expense is for a specific medical condition.

I understand that I am required to reimburse the Plan for any improperly paid amounts and that failure to repay may result in adverse income tax consequences.

I understand that any amounts remaining in my MEDFLEX account that have not been used for eligible expenses incurred during the plan year (January 1 - December 31) must be claimed by March 31 of the following year or they will be forfeited in accordance with plan provisions and Internal Revenue Code requirements.

Employee Signature _____ Date _____

KEEP A COPY FOR YOUR RECORDS

*MAIL OR FAX COMPLETED FORM TO:* Progressive Benefit Solutions, LLC (PBS), 14 Business Park Drive #8, Branford, CT 06405
CLAIMS FAX: (203) 974-4890 Phone: 1-866-906-8023 Local # (203) 985-1712

| | |
|---|---|
| Claim Form Purpose | IRS Code Publication 502 defines qualified medical care expenses as amounts paid for: (1) the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body; (2) expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes; (3) medical care expenses must be primarily to alleviate or prevent a physical or mental health defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins; (4) Medical expenses include transportation amounts primarily for and essential to medical care.<br><br>Only the cost of medical products and services allowed under the IRS Code Section 213 and the State of Connecticut MEDFLEX Plan Document are eligible for reimbursement. If these medical products and services include expenses that can be provided for both a medical and cosmetic, capital expenditure, personal, living and/or family purpose, a Medical Necessity Form Letter must be submitted along with your MEDFLEX Claim Reimbursement Form. You may download a Medical Necessity Form Letter from the OSC website at http://www.osc.ct.gov/empret/medflex/index.html, the PBS website at www.ctpbs.com, or by contacting 866-906-8023.<br><br>Out-of-pocket medical expenses may be reimbursed for the employee, their spouse and their IRS eligible dependents so long as: (1) expenses are qualified under IRS Code Section 105 and 213; (2) all other sources of reimbursement are exhausted (ex. health insurance plan); (3) reimbursement will not be sought from any additional source and; (4) documentation to substantiate expenses must be maintained and submitted for verification. A sample listing of eligible over-the-counter and medical products and services and ineligible expenses may be downloaded from the OSC website at http://www.osc.ct.gov/empret/medflex/index.html, the Plan's administrative services provider, PBS website at www.ctpbs.com or by contacting 866-906-8023. Further information regarding eligible expenses is available through IRS Publication 502 and IRS Code Section 213. |
| Instructions | In order to accurately process your claim, please complete the Claim Reimbursement Form in its entirety. Keep in mind that unless a change has occurred, SSN, address, daytime phone number and email address need only be provided at initial claim submission thereafter name & employee number is sufficient.<br><br>Pre-paid Benefits Card - If you've used your pre-paid benefits card to pay for MEDFLEX eligible expenses, check the box and submit copies of expense receipts to this claim form. The Claim Reimbursement Information section does not need to be completed.<br><br>If you have not used the MEDFLEX Pre-Paid Benefits Card and are seeking eligible MEDFLEX claim reimbursements, complete the Claim Reimbursement Information section and attach substantiating receipts.<br><br>Enter the following code types for eligible expenses: M - Medical; D - Dental; Rx - Prescription Medications; OTC - Over the Counter Medications; V - Vision; H - Hearing |
| Reimbursement Substantiation Guidelines | Acceptable supporting documentation includes:<br><br>• An Explanation of Benefits (EOB) from the insurance carrier indicating the patient date of service and out-of-pocket expenses associated with the claim.<br><br>• An itemized statement from the service provider for expenses not covered by insurance. The statement must include: (1) the patient's name; (2) date of service; (3) description of procedure; (4) physician name and (5) the service charge.<br><br>• Prescription Drugs - A statement from the pharmacy indicating: (1) pharmacy name; (2) patient name; (3) date of prescription fill; (4) patient cost (ex. co-pay); (5) Rx number and ; (6) name of drug.<br><br>• Eligible Over-the-Counter (OTC) Medications - A completed Letter of Medical Necessity Form including an itemized cash register receipt indicating: (1) medication name; and (2) OTC purchase date.<br><br>Note: IRS regulations stipulate that cancelled checks, balance forward statements, and credit card and/or cash receipts cannot be used to substantiate expenses (itemized cash register receipts are acceptable substantiation for eligible over-the-counter expenses not requiring a Letter of Medical Necessity Form). |

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