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Wellmark

Wellmark Blue Cross Blue Shield of Iowa
Wellmark Blue Cross Blue Shield of South Dakota

BluePriority Flex℠

Request For Reimbursement

1. Employee Information – Complete all sections.

☐ Check box if new address	Name			Social Security Number (optional) / Employer
	Home Address		E-Mail Address	
	City	State	Zip (9 Digit if Known)	Daytime Phone Number ( )

Sign Here

Employee Signature Required

Employee Certification

I request reimbursement from the following reimbursement account(s) for the expenses itemized below. I certify that the expenses for which reimbursement is requested under the reimbursement account(s) were for services received either by myself or my eligible dependent(s). I also certify that I or my eligible dependent(s) have received the services described on the dates indicated, and these are my out-of-pocket expenses that qualify as valid expenses under the plan and the Internal Revenue Code. I certify that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan covering health benefits. I also certify that these expenses are to alleviate a medical condition and not just merely beneficial to my general health. I understand that if I, my spouse, or dependents make contributions to a Health Savings Account (HSA) or receive HSA contributions from anyone else, I must have a Limited Purpose Medical Reimbursement Account which can only pay qualifying expenses related to vision and dental care. I further understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. To the best of my knowledge and belief, my statements on this form are complete and true.

Signature _____ Date / /

2. Medical Reimbursement – Attach an Explanation of Benefits, an itemized receipt, or other 3rd party verification *(8 ½ x 11 paper photocopies)* of each expense claimed, indicating the service(s) provided, date(s) of service, and charges. Balance forward statements, cancelled checks, and credit card receipts are NOT acceptable documentation for reimbursement.

Person Receiving Care	Relationship	Date Expense Incurred	Description of Expense	Total Expense	Amount Paid or Payable Under Another Plan or Source	Reimbursement Requested
		/ /				
		/ /				
		/ /				
		/ /				
		/ /				
					Total Reimbursement Requested	$

3. Dependent Care Reimbursement *(day care expenses)* – Obtain care provider's signature in the space below *or* attach an itemized receipt or other 3rd party verification *(8 ½ x 11 paper photocopies)* of each expense claimed, indicating date(s) of care and total charges. Balance forward statements, cancelled checks, and credit card receipts are NOT acceptable documentation for reimbursement. IRS regulations allow payment for services that have already been provided, not for services to be provided in the future.

Dependent Receiving Care	Relationship	Age	Date(s) of Care	Care Provider Name and Social Security # or Federal Tax I.D. #	Reimbursement Requested
				Total Reimbursement Requested	$

I certify that the expenses shown are valid.
Signature of Dependent Care Provider _____ Date _____/_____/_____

4. Mail, fax or email your claim form, with documentation, to:

Flexible Benefits
PO Box 14585
Des Moines, IA 50306-3585

Phone (800) 624-2755
Fax (515) 376-9002
wellfsa@wellmark.com

access account information and additional forms at: www.wellmark.com/flex

Plan Administrator Use Only

Notes:

M _____ **D** _____

Did you remember to:

- ☐ **Sign and date your claim form**
- ☐ **Provide proper documentation**
- ☐ **Read the account guidelines on the back**
- ☐ **Retain original documents for your records as we do not return documents**

FAILURE TO COMPLETE ALL APPROPRIATE SECTIONS OF THE CLAIM FORM OR SUBMIT LEGIBLE ITEMIZED RECEIPTS FROM YOUR PROVIDER MAY DELAY THE PROCESSING OF YOUR CLAIM(S).

GUIDELINES FOR ELIGIBLE REIMBURSEMENTS

GENERAL

- If you have not submitted the medical, dental, or other expense(s) to the applicable insurance plan(s), please do so prior to submitting this form.
- If you are reimbursed for ineligible expenses, those reimbursements may be refundable to the employer or taxed as ordinary income and certain penalties may apply as required by the Internal Revenue Code. Ineligible expenses include overpayments of reimbursable expenses, expenses that have already been paid from some other source, expenses for other than vision and dental services under a Limited Purpose Medical Reimbursement Account, and expenses not eligible for reimbursement as described by the Plan or as provided by the IRS.
- Cafeteria plans may only reimburse expenses incurred in the plan year. An expense is incurred when the service that gives rise to the expense is provided; when the expense is paid is irrelevant.
- In general, Section 125 of the Internal Revenue Code governs the tax status of flexible (cafeteria) benefit plans, of which employee reimbursement accounts are a part. Eligibility for pre-tax reimbursement is covered specifically in Code Sections 105 and 106 (Accident/Health Plans) and Section 129 (Dependent Care).
- If you have a General Purpose Medical Reimbursement Account, none of you, your spouse, or dependents are eligible to make contributions to or receive contributions in an HSA.
- For specific detail on claim filing, reimbursement, and review procedures, please reference your Summary Plan Description.

MEDICAL REIMBURSEMENT

- **Covered by Insurance - Expenses for services or items must be submitted to your insurance company before submitting for reimbursement under your flexible spending account. When you receive the Explanation of Benefits Statement (EOB) from your insurance company, include a copy with this complete claim form. If you have a copay, attach an itemized statement from your provider.**
- **Not covered by insurance - For services or items submit an itemized statement from the provider showing the provider's name/address, patient name, date the service was provided, a description of the service, and the amount charged along with this completed claim form. Orthodontia claims require an itemized statement/payment receipt, the orthodontist's contract/payment agreement or monthly payment coupons.**
- **Prescription (Rx) drugs and medicines - require a print-out of the prescriptions from your pharmacy or must be clearly identifiable on an itemized receipt, that includes the name and Rx number of the drug.**
- **Over The Counter (OTC) drugs and medicines (except insulin) - purchased after December 31, 2010 will require a prescription from your attending physician to be paid or reimbursed.**
- **Refer to www.wellmark.com/flex for a list of eligible expenses for reimbursement under a General Purpose Medical Reimbursement Account.**
- **Only qualifying expenses related to vision and dental care will be paid or reimbursed from a Limited Purpose Medical Reimbursement Account.**
- **You may be reimbursed for expenses for yourself, your spouse, and eligible dependents(s).**

DEPENDENT CARE REIMBURSEMENT

- Expenses to provide care for your eligible dependents may qualify for reimbursement. Eligible dependents include your qualifying child under age 13, your disabled spouse or disabled qualifying child who lives with you for more than half the year, and a disabled qualifying relative who lives with you for more than half the year, for whom you provide over half his or her support.
- To be eligible, you must be working while your dependents receive care. Also, if you are married, your spouse must be: a wage earner, a full-time student for at least 5 months during the year, or disabled and unable to provide for his or her own care.
- Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:
  - licensed nursery schools and licensed day care centers. The cost of a Kindergarten program is NOT a childcare expense for which you can be reimbursed if the program's intent and purpose is primarily educational.
  - individuals – other than your dependents – who provide care for your child(ren) in or outside your home, or for your disabled spouse or dependent parent in your home.
  - housekeepers, maids or cooks in your home, to include their food and lodging in your home, as long as their services include care of your eligible dependent(s).
- You will be required to provide the name, address, and social security number (or other taxpayer I.D. number) of your day care provider on your federal income tax forms at year-end.
- If claims submitted are greater than the balance in your dependent care account, reimbursement will be limited to your account balance. The un-reimbursed amount will carry forward to subsequent months in the plan year; you need not resubmit.
- IRS regulations limit the amount of reimbursement expense for dependent care to the lower of the annual earned income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns $250 per month (one dependent) or $500 per month (two or more dependents).
- IRS regulations limit the amount you can contribute to the dependent care account to $5,000 for a single parent with children, $5,000 for a married parent filing jointly, and $2,500 for a married parent filing separately.
- Under IRS regulations, qualified individuals can receive a tax credit for dependent care costs. This credit can be claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Reimbursement Account. The maximum amount that can be used for the tax credit is reduced by the amount you use from the Dependent Care Reimbursement Account.