CORESOURCE

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COREFLEX

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Phone: 1-877-267-3359

SEE REVERSE SIDE FOR INSTRUCTIONS

Fax: 1- 501-221-9074

PLEASE NOTE IF ADDRESS IS A NEW ADDRESS

A. EMPLOYEE INFORMATION		
Name	Social Security Number	Employer Name
Address (ONLY IF NEW)	City	State Zip
Home Phone/Cell Number: (optional)	Work Phone Number: (optional)	Email Address: (optional)

B. HEALTH CARE SPENDING ACCOUNT

Covered by Insurance (Yes or No) SEE NOTE BELOW	Date of Service	Provider of Service	Person for Whom Service Provided	Relationship to You	Amount

TOTAL AMOUNT REQUESTED $0

C. DEPENDENT CARE SPENDING ACCOUNT *SEE #5 ON BACK OF FORM

Dates of Service	Provider of Service	Caregiver's SSN or ID#	Dependent's Full Name	Dependent's Date of Birth	Amount

TOTAL AMOUNT REQUESTED $0

D. CERTIFICATION

I certify that the following is true:

1. The expenses listed above were incurred by me and/or my eligible dependents and qualify for Reimbursement within the current plan year. (See reverse side for a description of eligible expenses.)
2. The expenses listed above are not eligible for reimbursement by any insurance plan.
3. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
4. The appropriate bills, receipts, Explanation of Benefit Statements or documentation for day care expenses are attached. Please keep copies of supporting documentation for your records Documents will not be returned.
5. For Over-the-Counter medications to be eligible expenses under the plan, they must be for the diagnosis, prevention or to specific medical condition and not just for the overall good health of the participant.

**NOTE: If a portion of your medical expense(s) is covered by insurance, please send an explanation of Benefits (EOB) for verification.

Employee Signature Date

Please return this form to:

CoreSource
Attn: Flexible Spending Department
P. O. Box 8215
Little Rock, AR 72221
Fax: 501-221-9074
Email address: coreflex@coresource.com

FLEXIBLE SPENDING ACCOUNT
CLAIM FILING INSTRUCTIONS

1. Please complete the claim form in full and attach copies of all receipts, invoices, or Explanation of Benefit (EOB) statements. Documentation must clearly indicate:

   - Date services incurred or supplies purchased
   - Name and address of the provider of services or supplies
   - Name of the person receiving the service or supply
   - Type of expense
   - Amount of expense
   - Total amount paid by any insurance company

2. If any insurance company did not or will not reimburse you for ANY portion of an expense that you are submitting, please mark across the top of the invoice or receipt "NOT PAID BY INSURANCE" and initial it. If it is an expense which is part of your deductible, a copy of the EOB which indicates that, must be attached.

3. DO NOT SEND CANCELED CHECKS OR STATEMENTS THAT ONLY INDICATE BALANCE DUE. THESE DO NOT SUPPLY THE REQUIRED INFORMATION.

4. Claims submitted without the necessary information will be returned to the claimant and may cause a significant delay in processing reimbursement checks.

5. For daycare claims, you will need to submit a receipt from the daycare provider showing that you have paid for the care. Include dates of service, Social Security or Tax ID number of the caregiver. This must be included on every claim. Charges for Kindergarten or private school programs that are strictly educational in nature are not covered. If your child is age 5-12 and in school, you are eligible to submit reimbursement for expenses for the following services: before and after school care & summer daycare & summer camp (excludes overnight camps).

6. Keep copies of supporting documentation for your records. We will not return what has been submitted

ELIGIBLE EXPENSES

Expenses, which can be legally reimbursed through the Health Care Spending Account, are those expenses allowed by the IRS as tax deductible medical expenses and are not reimbursed or paid for by a health care plan. These expenses must be incurred during the plan year. Such expenses include, but are not limited to the following:

MEDICAL EXPENSES

Abdominal Supports, if prescribed
Abortion Services
Acupuncture
Ambulance Hire
Anesthesia
Artificial Limbs/Prosthesis
Alcoholism
Back Supports
Birth Control Pills-prescribed by Doctor
Braces
Braille Books/Magazines
Chiropractic Services
Co-Payments& Deductibles for Insurance
Crutches/Wheelchair
Diabetic Supplies
Diathermy
Doctors Office Visits
Fertilization Services
Gynecological Exams
Immunizations
Midwife Expenses
Obstetrician fees
Orthopedic Shoes
Osteopath
Oxygen
Physical Therapy
Podiatrist
Prescription Drugs
Psychiatric Care
Psychologist
Sex Therapy
Smoking Cessation Programs-if prescribed by Physician
Special Foods (related to medical condition)
Sterilization Fees
Transplants
Vasectomy
Well Baby Care
X-Rays

DENTAL EXPENSES

Bridges
Co-Payments & Deductibles - Insurance
Crowns
Denture
Fillings
Orthodontics (expenses incurred/current plan year)
Dental implants

HEARING EXPENSES

Exams
Hearing Devices, Aids and Batteries
Special Communication Equipment for the Deaf

VISION CARE

Contact Lenses, Frames, Lenses
Contact Lens Solution & Heating Units
Laser Eye Surgery
Oculist, Optician &Optometrist Services
Radial Keratomy Surgery

INELIGIBLE EXPENSES

Expenses not eligible for reimbursement through the Health Care/ Dependant care Spending Account include, but are not limited to. the following;

Anti-Baldness Drugs
Bottled Water
Cosmetics, Toiletries, Toothpaste, etc
Cosmetic Surgery
[illegible] Care in an Institution
Electrolysis or Hair Removal
Funeral and Burial Expenses
Health Club Dues (unless prescribed by Dr.) Household and Domestic Help
Illegal Operations and Treatments
[illegible] Premiums
Maternity Clothes, Diaper Service
Nursing for Newborns
Uniforms
Vitamins (over the counter)
Tuition for Kindergarten