

c/o Benserco, Inc., 140 Sylvan Ave., Ste. 303, Englewood Cliffs, NJ 07632
 Tel: 201-592-6800, Toll Free: 800-365-0082, Fax: 201-947-9192

MEDICAL SPENDING ACCOUNT CLAIM FORM

Reimbursement will be made up to \$4,400 per year, with a maximum of \$2,200 per six-month insurance period (Sept-Feb and Mar-Aug), and is subject to terms and conditions of the Plan. Claims may be submitted within one year of your date of service. Benefits are payable only after any payments that are allowable under any other medical insurance which covers you. Please submit an explanation of benefits from your primary insurance carrier whenever possible.

If you cannot provide evidence that you have other group health plan coverage that meets minimum value standards under the Affordable Care Act, you will only be eligible for reimbursement of dental and optical “excepted benefits.”

Name:	Primary Insurance Carrier:
Member ID#:	Policy Group Number:
Address:	Name of Insured (e.g. self, spouse, etc.):
	Insured’s I.D. Number
Telephone (Home):	Telephone (Business):

Date of Service	Service Provider	Category (Select code below)*	Amount Requested
	Name: _____ Telephone: _____ Address: _____		
	Name: _____ Telephone: _____ Address: _____		
	Name: _____ Telephone: _____ Address: _____		
	Name: _____ Telephone: _____ Address: _____		
	Name: _____ Telephone: _____ Address: _____		
		GRAND TOTAL:	

***1) Dental, 2) Deductible/Co-Payment** (i.e., uncovered expenses from another health plan; attach your explanation of benefits form from your primary insurance carrier as documentation), **3) Optical, 4) Mental Health** (Services must be performed by a psychiatrist, licensed psychologist, or MSW), **5) Chiropractic, 6) Wellness** (preventive exams, vaccinations, etc.), **7) Other** (Health expenses qualifying as deductible on your personal income tax are allowable, as outlined in IRS publication 502. For a copy call 800-829-3637, or call the Fund office for details.

I hereby authorize the health care provider or my insurance carrier to release any records necessary to verify this claim. I understand that this claim may be subject to audit and may require the submission of additional information.

Signature: _____ Date: _____

Please attach your proof of payment (paid receipt, cancelled check, etc.) along with a copy of the original invoice showing 1) the name and address of the provider, 2) the date of service, 3) the service performed, and 4) the amount charged. Please also forward any documentation from your primary insurance carrier (i.e. explanation of benefits) that paid in part or did not pay any of the above referenced claims.