Health Care FSA Claim

MAIL:
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CHAMPAIGN, IL
61826-7500

FAX:
877-760-7076

PHONE:
877-272-8880

ONLINE:
www.mywealthcareonline.com/bpcinc

##11BPC001##################

Employer: _____

Participant Name (please print): _____ SSN: X X X – X X – ____

Day Time Phone Number: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ Email Address: _____

☐ I have **Changed** My Address _____
Street City State ZIP

NOTE: Please do not send original documentation to BPC. All items submitted (receipts and otherwise) will be considered property of BPC and will not be returned to you. **The IRS has determined that cancelled checks, check carbons, balance forward or previous balance statements, as well as charge card receipts or statements are NOT acceptable documentation of expenses.** Expenses **MUST** have been incurred during the coverage period. All submitted bills/receipts/statement/EOB **must be itemized** with the date of service, service provided/or item purchased, and the amount charged. **All supporting documentation MUST be included**

Expense Description	Dates of Service (From—To)	Provider	Claimant/ Patient	Amount of Purchase
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			AMOUNT REQUESTED:	$

FSA = Medical Flexible Spending Account (Flex)

I have included supporting documentation from an independent third party verifying that the eligible expense(s) has/have been incurred in the amount of the listed expense. By my signature below, I certify that all of the expenses listed on this form are valid and eligible and have been incurred by myself and/or my spouse and/or my eligible dependents. The expense(s) has/have not been discounted via coupon, rebate or other discount program, nor reimbursed in any way, and I will not seek reimbursement. I understand that the expense(s) for which I am reimbursed may not be used as deductions or credits on my, or my spouse's, income tax return. If I have inadvertently received payment for an ineligible expense or have been incorrectly reimbursed, I agree to provide repayment to the Plan.

A signature is required on each claim form that is submitted.

Participant Signature: _____ Date Submitted: _____

SUBMIT YOUR CLAIMS

www.mywealthcareonline.com/bpcinc

CONTACT YOUR SPECIALIST

www.bpcinc.com/contact