Discovery Benefits
FSA • HSA • HRA • TSA • COBRA • Billing Solutions

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

# Out-of-Pocket Reimbursement Request Form

**This form is not for Discovery Benefits Debit Card claims**

## Completion Guide

Claims can also be submitted by logging in to your account at www.discoverybenefits.com. This form is for reimbursement of any out-of-pocket expenses where your Discovery Benefits debit card was not used. Documentation to substantiate purchases made with your Discovery Benefits debit card must be uploaded via your online account or submitted with a copy of a Receipt Reminder.

### Step 1: Participant Information

- Complete the required fields (*).
- Changes to your profile can be made by logging in to your account at www.discoverybenefits.com.
- Please write legibly. Missing information may delay the processing of your claim.

### Step 2a: Medical Reimbursement Information- You may submit one form per receipt or lump all receipts together and only submit one form. Submitting one receipt per form is the preferred method.

- **Plan type:** Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Date of service(s):** Provide the date or range of dates the expense was incurred including the year.
- **Merchant name**: Provide the name of the merchant or facility where the expense was incurred. *If filing a lump sum claim that includes multiple merchants, please write "Multiple" in this box.*
- **Person receiving the product or service**: Provide your name or the name of the tax dependent for which the service was provided or the product was purchased. *If filing a lump sum claim for multiple people, please write "Multiple" in this box.*
- **Description of services**: Provide a brief description of the service.
- **Amount requested for reimbursement**: Total amount requested.

### Step 2b: Dependent Care Reimbursement Information- Having your dependent care provider sign this form is the preferred method to file for reimbursement. If you want to file a claim online, you may have your provider sign this form and upload this form to the claim.

- **Plan type:** DCA
- **Date range of services, including the year:** Provide the date or range of dates the expenses were incurred including the year.
- **Name of provider**: Provide the name of the dependent care provider or facility.
- **Provider's signature**: Dependent care provider's signature.
- **Amount requested for reimbursement**: Total amount requested.

### Step 3: Participant Certification

**Submit the completed form with the supporting documentation to Discovery Benefits.**

**Mail:** PO Box 2926; Fargo, ND 58108-2926
**Fax:** 1-866-451-3245

**Documentation Requirements**

Documentation for eligible *medical* expenses, required by the IRS, includes a third party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)
- Name of the merchant/provider

Verification of *dependent* care expenses is required by the IRS. The dependent care provider's signature on this form is the preferred method. We also accept documentation from the provider. The provider documentation must include the following information:

- Dates of service (that have been incurred)
- Description of service
- Dollar amount charged for incurred services
- Name of the provider

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/eligible expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

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*= Required Fields

## Step 1: Participant Information

| * Participant Name (First, MI, Last) | *Social Security Number |
|---|---|
| | - - |

| * Employer Name (Do not abbreviate) | Employee ID |
|---|---|
| | |

Updates or changes to your information can be made by logging into your account at www.discoverybenefits.com.

## Step 2a: Medical Reimbursement Information – You may submit one form per receipt or lump all receipts together and only submit one form. Submitting one receipt per form is the preferred method.

| *Plan type | *Date of service | *Merchant name | *Person receiving the product or service | Description of the services | *Amount requested for reimbursement |
|---|---|---|---|---|---|
| | | | | | |

***Plan Types: MSA**-Medical Spending Account; **LMSA**-Limited Medical Spending Account; **EMSA**-Employer Funded Medical Spending Account; **RMSA-**Retiree Medical Savings/Spending Account; **PRA**-Premium Reimbursement Arrangement; **HRA**-Health Reimbursement Arrangement

## Step 2b: Dependent Care Reimbursement Information – Having your dependent care provider sign this form is the preferred method to file for reimbursement. If you want to file a claim online, you may have your provider sign this form and upload this form to the claim.

| *Plan type | *Date range of services, including year | *Name of provider | *Provider's signature | *Amount requested for reimbursement |
|---|---|---|---|---|
| DCA | | | | |

## Step 3: Participant Certification

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Dependent Care Account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. By submitting this form I certify the above.

I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

*F001*