Flexible Spending
Medical Expense Claim Form

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6810, 1-877-737-7730
Fax: (605) 328-7207
sanfordhealthplan.com

Employee Information

Name: ____ ID Number: ________________________

Street: ____ Phone: (______) ____________________

City/State/Zip: ______________________________________ Employer: ____________________________

Please Note: All claims must be incurred during the plan year; prepayment for future dates of service is prohibited. Eligible dependents for medical expense reimbursement are a participant's spouse and/or dependent child (age restrictions apply).

Medical Care Expenses:

Please check the appropriate box(es) corresponding with your claim(s)

- ☐ Medical/Dental Expenses (covered by insurance): Enclosed is an Explanation of Benefits from my insurance, which is required even if charges are applied to deductible or out-of-pocket liability.
- ☐ No insurance: Enclosed is a detailed receipt showing an expense not covered under my insurance plan, or I do not have insurance.
- ☐ Orthodontic Expenses: Enclosed is proof of payment; a treatment plan/contract is attached or has been previously submitted.
- ☐ Prescription Expenses: Enclosed is a prescription drug co-pay receipt indicating the patient name, drug name, date filled and the amount paid by the patient.
- ☐ Over-the-Counter Expenses: Enclosed is a detailed receipt showing the over-the-counter item. If over-the-counter drug or medicine is purchased on or after 01/01/2011, I have attached a written doctor's prescription for this over-the-counter drug or medicine.

Unacceptable documentation includes: balance forward statements, cancelled checks, credit card receipts, and statements showing estimated insurance. Processing time could be delayed if proper documentation is not provided.

Date(s) of Service	Patient Name	Age	Provider	Amount Requested
			Grand Total:	

Employee Certification

I, the undersigned, certify that the above expenses were incurred by me (and/or my spouse and/or eligible dependents) and have been incurred within the period of coverage during the plan year. The above expenses have been paid by me (or them), were not reimbursed by any other plan and to the best of my knowledge and belief, are eligible for reimbursement under my flex account. I have attached Explanation of Benefits statement(s) from all insurance plan(s) and a letter of medical necessity (when necessary) of these expenses. I understand that I cannot use the expenses reimbursed through this FLEX account as deductions or credits when filing my income tax return. If audited, I understand that it is my responsibility (not my employer's) to provide written proof that these expenses were actually incurred and eligible for reimbursement.

Employee Signature: ____ Date: __________________

Unsigned claim forms will not be considered for reimbursement.

Did you remember:
- ☐ Sign and date your claim form
- ☐ Read the account guidelines on the back
- ☐ Provide proper documentation
- ☐ Retain original document for your records

Medical Expense Spending Account Reimbursement Guidelines

Contact Information

Sanford Health Plan
Flexible Benefits Department
PO Box 91110
Sioux Falls, SD 57109-1110

Phone: (605) 328-6810
Fax: (605) 328-7207
E-mail: flex@sanfordhealth.org
Online Inquiry: sanfordhealthplan.com

Submitting Medical Expense Claim Forms for Reimbursements

To request a medical expense reimbursement, the participant must complete and submit the appropriate claim form, along with proper documentation to Sanford Health Plan. Claim forms can be found on www.sanfordhealthplan.com. *Please note: Some reimbursements may require a letter of medical necessity.*

Pharmacy Expenses: Proper documentation includes the receipt from the pharmacy indicating the prescription filled, the date, cost, etc.

Medical Out-of-Pocket Expenses: Proper documentation includes the Explanation Of Benefits (EOB) from your insurance company, or an itemized statement showing all expenses and applied insurance payments.

Vision/Dental Expenses: Proper documentation includes itemized statements indicating the services provided, dates of service, cost, etc. If insurance is provided for any of the services, an EOB must be submitted as the participant cannot be reimbursed for any amount paid or discounted by insurance.

Over-the-Counter Expenses: Proper documentation includes cash register receipts clearly showing the item purchased. Over-the-counter drugs and medicines purchased are not eligible without a doctor's prescription for the over-the-counter drug or medicine.

Adds/Changes/Terminations

Election amounts will stay in effect throughout the plan year, unless a qualified life event occurs. If a qualified life event occurs, you must notify your HR Department within 30 days of the qualified life event in order for eligibility changes/election changes to occur. All eligibility changes/election changes must be consistent with the qualified life event.