CONEXIS
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Request for Reimbursement
Health Care Spending Account

Instructions

1. Employee must complete **Employee Information** – be sure to indicate if this is a new address
2. Complete **Claim Information** in its entirety. Please ensure that your supporting documentation clearly indicates the requested amount.
   Eligible expenses include but are not limited to: Acupuncture, Alcohol & Drug Rehabilitation (inpatient treatment only), Ambulance, Artificial Limbs, Artificial Insemination/Invitro Fertilization/Fertility Enhancement, Blood Pressure Monitoring Devices, Body Scan, Birth Control Pills/Condoms/Spermicide, Chiropractor, Co-Insurance and Deductible, Contact Lenses & Cleaning Solutions, Crutches, Dental Treatment, Dentures, Diagnostic Tests, Eye Exam, Eye Glasses/Prescription Glasses, Flu Shots, Hearing Devices, Hospital Services, Immunizations (e.g., well-baby shots), Insulin, Laboratory fees, Lamaze classes relating to childbirth, Laser Eye Surgery / Lasik, Learning Disability Treatment, Medical Alert Bracelet/Necklace, Obstetric Treatment, Orthodontia, Over-the-counter pregnancy tests, Over-the-counter medications to treat a specific medical condition, Oxygen, Physical Exams, Physical Therapy, Podiatry Treatment, Prescription Drugs, Psychiatric Treatment, Psychological Treatment, Radial Keratotomy, Smoking Cessation – prescription only, Surgery & Related Expenses, Tubal Ligation or Vasectomy, X-rays
   Ineligible expenses include but are not limited to: Cosmetic surgery and procedures, Expenses for services rendered outside the coverage period, Expenses reimbursed by an insurance provider or another health plan, Hair loss items, Herbs/Vitamins/Supplements that do not require a prescription for use, Insurance Premiums, Long term care services, Marriage Counseling, Personal Use Items, Teeth Whitening
3. Check the appropriate box in Supporting Documentation section and attach Acceptable Supporting Documentation as described below:
   a) Itemized Statement or bill from your provider including:
   - Provider name
   - Patient name
   - Description of service
   - Original date of service (the date of service, not the date of payment must fall within the plan year for which you are enrolled)
   - Patient portion of charge(s)

   b) Explanation of Benefits (EOB) from your insurance carrier
   c) Pharmacy Statement including:
   - Patient name
   - Prescribing physician
   - RX number
   - Name of the drug
   - Date the RX was filled
   - Co-payment amount

   ***Unacceptable Documentation includes the following:**
   - Cancelled Checks
   - Credit / cash receipts (An itemized cash register receipt is acceptable for eligible over-the-counter expenses)
   - Balance forward statements

   --When attaching small receipts, we suggest you tape them to a standard size sheet of paper
4. Sign and date **Employee Certification**
5. **Submit Claims To**:
   CONEXIS Cafeteria Plan Services
   P.O. Box 227197
   Dallas, Texas 75222
   Fax: (888) 866-3312 Phone: (866) 279-8385

Medical expenses which have been reimbursed under this plan are not deductible for income tax purposes.

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Employee Information

Employer Name _____ ☐ Check here if this is a new address

Employee Name _____ Social Security Number _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ Zip Code _____

Claim Information

Patient Name	Date of Service	Type of Service	Requested Amount
			$
			$
			$
			$
			$
	Total Amount Requested (continue on additional page if necessary)		$

Supporting Documentation

Attach Supporting Documentation (*see list of acceptable documentation above)

☐ I have attached copies of Explanation of Benefits (EOBs) for deductible and coinsurance requests.

☐ I have attached itemized bills for expenses not covered by medical, dental or vision insurance.

Employee Certification

I certify the expenses listed for reimbursement are eligible health care expenses under the Internal Revenue Code and my employer's Flexible Benefits Plan. I also certify the services listed above have been received by me, my spouse or my dependent. I further certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person. My employer does not accept responsibility for direct payment to any individuals other than the employee. I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that any unused contributions will be forfeited to my employer at the end of the plan year.

_____ _____

Employee Signature Date