Claim Form Instructions
Flexible Spending Accounts (FSA)

Complete all sections of the claim form. PLEASE TYPE OR PRINT. Once you have complete the form, SIGN and DATE it. Retain copies of all documents for your records. Submit your claim to INNOVA via fax, upload, or mail. Faxing your claim will expedite reimbursement. Contact your employer for reimbursement schedule.

Failure to comply with the following instructions may result in your claim being delayed or returned to you.

Before requesting reimbursement from your Reimbursement Account, you must **first** submit your expenses to any other benefit plan or program under which you are eligible for benefits. If your expenses are not paid in full or are not covered, you may then request reimbursement from your Healthcare Reimbursement Account.

To be eligible, expenses must be incurred out of medical necessity. Cosmetic procedures or expenses related to general health and well-being are not eligible for reimbursement. ***Effective January 1, 2011 a doctor's prescription is required for over-the-counter medicines and drugs.***

Qualified Dependent: In general, a child is a qualifying child if the child is a U.S. Citizen or national or a resident of the U.S., Canada or Mexico and; 1) has the same principal residence of the taxpayer for more than half of the taxable year; 2) has a specified relationship to the taxpayer (such as child, stepchild, fosterchild, sibling or stepsibling or the descendent of one of the above; 3) has not attained the specified age (age 27) at the end of the tax year or is totally and permanently disabled at any time during the year; or 4) did not provide more than one-half of his/her own support during the year. A qualifying relative is someone who is not a qualiying child but meets the relationship, income and support tests of Code Section 152. Please remember, a child must be under age 13 in order to qualify for dependent care assistance.

A. **Indicate date of service, type of service (medical,dental, hearing, vision care, etc), service provider, who incurred the expenses and their relationship to you (i.e., self, spouse, or dependent), and the amount to be reimbursed from your Healthcare Reimbursement Account. If you did not submit a claim to your insurance carrier, please explain why in the "Submitted to Insurance" section.**

B. **SUPPORTING DOCUMENTATION:**

1. **An Explanation of Benefits from your insurance carrier if the expenses were eligible for reimbursement from any other benefit plan or program but were not paid in full; OR**
2. **Detailed invoice(s) or statement(s) indicating ALL of the following:**
    - **Provider's name and address**
    - **Date of service**
    - **Itemized breakdown of services and supplies or name of over-the-counter item. *Effective January 1, 2011 a doctor's prescription is required for over-the-counter medicines and drugs.***
    - **Total charges**
    - **Recipient of services/Patient's name**
    - **Amount paid by insurance, if any**

C. **UNACCEPTABLE DOCUMENTATION**
    - **Credit card receipts**
    - **Canceled checks**
    - **Balance forward/Previous balance/Payment Only statements**