Fax Claims to:
(855) 306-1098 Attn: TPA Claims Dept.
or email to: claims@cicbcg.com

ADVANCED BENEFIT SOLUTIONS, INC.
6 N. Mitchell Street, PO Box 700, Cadillac, MI 49601

Benefit Consultants & Plan Administrators

Total Pages_____

HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

Employer's Name: Manistee County Employee Name: _____
Please Print or Type

Social Security Number:_____ Daytime Phone: (_____)_____

Address:_____ ☐ √ If New Address

To receive reimbursement for eligible expenses incurred during the plan year, mail OR fax (not both) this completed and **signed** claim form along with IRS-required documentation of the expense from an independent third party (such as Insurance EOB*, receipt or statement), **which must include all** of the following:

- **Date of service/purchase**
- **Name of person receiving service**
- **Name of provider of service**
- **Type of service / type of prescription / supply provided** (name of OTC item must be printed directly on the receipt by the register or else include a copy of the product packaging with price tag on it matching amount paid on receipt)
- **Amount charged for each service/supply or the amount not reimbursed by insurance**

CREDIT CARD RECEIPTS, CANCELLED CHECKS, CHECK COPIES AND CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE

Health Care Expense Reimbursement (HRA / Employer Funded)

Date of Service	Physician or other Provider Of Service	Type of Service/Supply Purchased	Amount Paid	Amount to be Reimbursed

Total to be Reimbursed $_____

I hereby certify that all the medical expenses on this reimbursement form have been incurred by me, my spouse and/or my eligible dependents during the plan year and qualify for reimbursement. I understand that medical expenses are deemed to have been "incurred" when the services giving rise to the claim are rendered, regardless of when I am formally billed, charged or pay for the service. I certify the expenses are medical expenses as defined in Section 213(d) of the Internal Revenue Code of 1986, and are not for cosmetics, cosmetic surgery, premiums on accident or health insurance or coverage for long-term care services. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I also understand that any reimbursed expenses cannot be used to claim a deduction or credit on my personal income tax return. This is not a guarantee that the payment is tax-free if the requested items do not meet IRS rules.

Employee Signature:_____ **Date:**_____