HSA Reimbursement Form

Name_______________________________________Employer___________________________________
Social Security#____________________________________Day Phone___________________________
Your e-mail Address (for claim-related matters only)____

Complete all sections of the claim form and sign/date where indicated

Health Savings Account (HSA) Expenses				
Date Expense Incurred	Name of Provider	Expense Description	Person for Whom Expense was Incurred	Amount
			HSA Expense Claims	

Please keep a copy of your signed form and your original receipts

Acceptable forms of documentation of expenses include an Explanation of Benefits from the participants health care provider or an itemized receipt/statement on the provider's letterhead containing the following information:

- Type of service or product provided
- Date expense was incurred
- Name of participant or dependent for whom the service/product was provided
- Person or organization providing the service/product
- Amount of expense

The following are **not allowable** under Code Section 125 of the IRS:

- Cancelled checks or Credit card receipts as stand-alone documentation
- Billings that list previous balance, balance forward, or paid on account
- Amount paid by health care provider

NOTE: Documentation showing all required information *must* be kept for your records in the event of an IRS audit.

Reimbursement Method

☐ **Option 1 - Check.** Allow 7-10 business days to receive your check. **A $2.00 fee will be deducted from your HSA.**

☐ **Option 2 - Transfer my funds to the following account****

☐ **Use ACH information already on file with BMS**

I hereby authorize Benefit Marketing Solutions, LLC to initiate credit entries to my Checking or Savings Account at the depository named below.

Bank Account Type: ☐ Checking ☐ Savings

Bank Name: City/state:

Routing number: Account number:

READ CAREFULLY - I request reimbursement from my Health Savings Account for the expenses itemized above. I certify that the expenses for which reimbursement is requested under the HSA were for services received by me or my eligible dependent(s) on the date(s) indicated and these are my out-of-pocket expenses that qualify as valid expenses under the plan(s) and the Internal Revenue Code. I certify that I have not been reimbursed for the itemized expenses and that I will not seek reimbursement under any other plan. I also certify that any medically related expenses itemized above are to diagnose, alleviate or prevent a medical condition and not merely beneficial to general health. If this claim is for medical expenses: I understand that if I, my spouse, or dependents make contributions to a Flexible Spending Account (FSA) or Health Reimbursement Account/Arrangement (HRA), I must have a Limited Purpose or Post Health FSA or a Limited Purpose, Post Deductible, Suspended or Retirement HRA. I further understand that reimbursed expenses cannot be claimed as credits or deductions on my personal tax return. I understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim and that if an expense for which reimbursement is claimed is not a proper expense under the plan(s), I will be liable for payment of all related taxes and penalties including federal, state or city income tax on amounts paid from the plan(s) which relate to such expense.

______________________________________ ________________________
Employee Signature Date

Remit Claim to:

MAIL: BMS LLC, P.O. Box 43653 Louisville, KY 40253-0653 **FAX**: (502)244-1162 **E-MAIL**: claims@bmsllc.net

www.bmsllc.net - Visit our website to create an online HSA claim submission!

© BMS LLC