

DEBIT CARD / MEDICAL REIMBURSEMENT REQUEST FORM

Employee Name: _____ SS#: _____ Employer Name: _____

Employee Address: _____ City: _____ State: _____ Zip: _____

Employee Home Phone #: _____ Employee Work Phone #: _____

INSTRUCTIONS: Use this form to request reimbursement for all eligible medical expenses whether paid by debit card, cash or check. Sign and date the form and submit to Nation Plan Administrators (NPA).

Fill in all the information requested below for medical expenses incurred by you, your spouse, or your eligible dependent.

See following page for complete instructions.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE#3	EXPENSE #4
Date(s) Service Actually Provided	10/1/10				
Name of Person Receiving Medical Service & Relationship to You	Fred Jones <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Type of Service (Office Visit Copay, Dental, RX, Vision, etc)	Dental				
Total Expense	\$100.00	\$	\$	\$	\$

Total Amount Claimed: \$

To the best of my knowledge and belief, my statements in this Medical Reimbursement Request Form are complete and true. I certify that the services described above were received on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Plan or any other health plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is requested for prescribed drugs, I certify that such drugs are not prescribed for cosmetic purposes. I understand that these expenses may not be used to claim any federal income tax deduction or credit. I also acknowledge that should the actual annual expenses claimed be less than the amount available, such balance shall remain with the employer at the end of the Plan Year.

Employee Signature

Date

Email Address



NATIONAL PLAN ADMINISTRATORS, INC.
 P.O. BOX 161630
 AUSTIN, TX 78716
 PHONE: (512) 327-6481 or (800) 880-2776
 FAX: (512) 275-9396 or (800) 982-8140
 Email: 125@natlplan.com
 WEBSITE: www.natlplan.com

QUALIFYING MEDICAL EXPENSES

The Section 125 Cafeteria Plan Document contains the rules governing what expenses are and are not reimbursable. Below are some examples to give you a general idea. Please contact National Plan Administrators, Inc. if you have any questions about whether a particular expense is reimbursable. **The following changes become effective January 1, 2011 under the Internal Revenue Code: (1) A doctor's prescription is required for over-the counter drugs and medications; and (2) A debit card can no longer be used to purchase over-the-counter drugs and medications.**

Examples of qualified expenses for which you may be able to receive reimbursement:

Deductibles and co-payments for medical, prescription drug, vision and/or dental expenses.

Over the counter drugs and items that are used to alleviate or treat a personal injury or sickness.

Eye exams, eyeglasses, contact lenses and other vision expenses.

Hearing exams, hearing aids and batteries.

Individual psychotherapy.

Chiropractic expenses.

Orthodontia monthly and down payments.

Acupuncture with letter of medical necessity.

Examples of non-qualified expenses for which you cannot be reimbursed:

Over the counter items or vitamins even if prescribed; toothpaste, toiletries, any item or drug is for general good health.

Cosmetic surgery or similar procedures which are directed at improving patient's appearance but do not meaningfully prevent or treat illness or disease.

Teeth bleaching, whitening or veneers.

Health club dues.

Weight reduction or management related expenses unless submitted with letter of medical necessity from physician.

Herbal remedies, drugs or supplements, even if prescribed.

PROCEDURE FOR SUBMITTING A CLAIM

Section 125 of the Internal Revenue Code stipulates the requirements for an expense to be reimbursed under a Medical Flexible Spending Arrangement (FSA):

- 1) The expense must be an eligible expense.
- 2) All payments from a flexible spending account must be documented. Some debit card purchases will be documented electronically and will not require you to submit a claim form. When a claim form is required, complete a Debit Card/Medical Reimbursement Request Form and send it to NPA with proper documentation. Canceled checks, adding machine tapes and credit card statements are not acceptable. The documentation must include:

Name of patient
Description of services, drugs or other
Name and address of provider
Date of purchase
Amount of expenses for which reimbursement is requested

- 3) There must be a signed statement that the expense has not been previously reimbursed and is not reimbursable under any health plan.

Additional Guidelines for Debit Card Use

A Debit Card must only be used for eligible expenses. Inappropriate use of a Debit Card may result in immediate termination of privileges under the FSA Plan. In addition, the claimant will be responsible for reimbursing all ineligible expenses to the employer.

When required, documentation of Debit Card purchases must be submitted to NPA within 5 days of the date of purchase.

NOTES: Debit Card/Medical Reimbursement Request forms are available on line at www.natlplan.com/employees.html.

Please keep a copy of all records submitted to NPA.