Reimbursement Request Form

Lifetime BENEFIT SOLUTIONS

Employer Name: _____

Participant Name (First, MI, Last): _____

Social Security Number:_____

Address: _____

City, ST, ZIP:_____

Date of Birth: _____ Phone Number: _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claimant Name	Date of Service	Amount	Plan Code	Type of Services/ Items Purchased	# of Miles	Claim Reference Number
John Sample	*10/1/2022*	*$150.00*	*F*	*Doctor visit copay*	*12*	*Example*
						01
						02
						03
						04
						05
						06

Use one of the Plan Codes below to indicate the account from which payment should be made. Your employer may not offer all the benefit types listed below and certain restrictions may apply. If your employer offers multiple benefit types, Lifetime Benefit Solutions will process the reimbursement based on the rules established by your employer. In this example, remaining expenses will be applied to your HRA, if eligible.

*Plan Code	Plan Code Description
F	Flexible Spending Account (FSA) or Limited Purpose FSA: Health Care Expenses Only. For Dependent Care expenses, use the Dependent Care Account Reimbursement Request Form located in the Forms section of **LifetimeBenefitSolutions.com**
H	Health Reimbursement Account (HRA) or Retiree Reimbursement Account (RRA)
P	Parking Account (cannot claim miles associated with Parking)
T	Transit Account (cannot claim miles associated with Transit)
I	Individual Insurance Policy Premiums
M	To submit for medical mileage associated with Debit card transactions. You will only be reimbursed for the medical mileage associated with the miles traveled, since you paid for the service with the Debit card.

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I have read the Reimbursement Request Instructions on the following page and agree to adhere to all terms specified. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

Mail to: Lifetime Benefit Solutions, Claims Dept, PO Box 211126 Eagan, MN 55121
Fax to: 877-256-7228
Call: Customer Service with questions at 800-327-7130.

Reimbursement Request Instructions

For All Account Types (FSA, HRA, Parking/Transit, RRA, Insurance Premium)

- For faster reimbursement processing, you may be able to submit your claims online at **LifetimeBenefitSolutions.com**.
- Complete the top section, including Social Security Number or Employee ID.
- Submit one expense (either a product or service) per row, even if items are contained on the same receipt.
- Label the receipts to correspond to the Claim Reference Number.
- If you have more items than the form can accept, use additional forms.
- Do not "lump" or group items together or write See Attached.
- All claims are subject to deadlines, as defined in your Summary Plan Description (SPD) .
- The expenses you submit must qualify as valid expenses under the terms of the Plan, and the claimant receiving the services must be a qualifying individual as defined in the Plan.
- Retain a copy of the Reimbursement Request Form and receipts for your own personal records.
- Call Lifetime Benefit Solutions Customer Service with questions at (800) 327-7130 during standard weekday business hours.
- Mail OR fax (but not both!) completed form with required documentation to:

  Lifetime Benefit Solutions Claims Dept.
  PO Box 211126
  Eagan, MN 55121
  Fax# (877) 256-7228

Reporting Medical Mileage

- Medical mileage rates are set by the IRS and can be applied to transportation primarily for, and essential to, medical care.
- Indicate the total number of miles incurred with each service provided (i.e. round trip miles to visit the doctor).
- Lifetime Benefit Solutions will apply the current mileage rate and include the mileage amount in your total reimbursement.
- You may be required to produce additional documentation for each mileage expense you claim.

Medical Claims for FSA, HRA and RRA

- For each medical claim covered by your insurance carrier, submit an Explanation of Benefits (EOB). If your claims are not submitted to your insurance carrier, provide an itemized bill showing: date of service, provider name, patient name, charged amount, and description of services rendered.
- Do not send credit card receipts, original receipts, or cancelled checks.
- Use Plan Code M to report medical mileage associated with a Debit card transaction. For example, if you drove 20 miles to a doctor's appointment, and paid your copayment amount with the Debit card, you should use Plan Code M to be reimbursed for the 20 miles you drove. You should still complete the full line of information, but you will only be reimbursed for the mileage, not the copayment amount.

Dependent Care Claims

- Please use the separate form titled Dependent Care Account Reimbursement Request Form.

Parking/Transit Claims

- The only type of parking that is eligible for tax-free reimbursement is qualified parking on (or near) the employer's facility, or on (or near) a location from which the employee commutes to work by public transportation. If the parking is on (or near) the employee's residence, it is not eligible for tax-free reimbursement.

Individual Insurance Premium

- The bill from the insurance carrier must identify participant, premium amount, coverage period, and policy number.

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