

Reimbursement Request Form

Completion Guide

* Claims can also be submitted by logging into your account at www.discoverybenefits.com. **Note:** If you filed the claim online, please do not complete this form. Simply upload the supporting documentation online or fax the confirmation page and supporting documentation to 1-866-451-3245.

Step 1: Participant Information

- Complete the required fields (*).
- Changes to your profile can be made by logging in to your account at www.discoverybenefits.com.
- Please write legibly. Missing information may delay the processing of your claim.

Step 2: Reimbursement Information

- **Plan Type:** Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Date(s) Expense(s) Incurred:** Provide the date or range of dates the expenses were incurred.
- **Merchant/Provider Name:** Provide the name of the merchant or facility where the expense was incurred.
- **Name of Person Receiving Product/Service:** Provide your name or the name of the tax dependent for which the service was provided or the product was purchased.
- **Claim Amount:** Provide the total amount requested for the specified expense.
- **Total Reimbursement Requested:** Total the amounts in the "Claim Amount" boxes.

Step 2b: Dependent Care Provider Signature and Certification

- Should the day care provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Step 3: Participant Certification

Submit the completed form with the supporting documentation to Discovery Benefits.

- Send your claim to:
Mail: PO Box 2926; Fargo, ND 58108-2926
Fax: 1-866-451-3245

Documentation Requirements

Documentation for eligible expenses, required by the IRS, includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses, required by the IRS, includes a third party receipt containing the following information (please be advised if a receipt is unavailable a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/eligible expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

Reimbursement Request Form

This form is for reimbursement of any out-of-pocket expenses. Claims can also be submitted by logging into your account at www.discoverybenefits.com. Documentation to substantiate purchases made with your Discovery Benefits debit card must be submitted with a copy of a Receipt Reminder or uploaded via your online account.

*= Required Fields

Step 1: Participant Information

* Participant Name (First, MI, Last)

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*Social Security Number

* Employer Name (Do not abbreviate)

Employee ID

Updates or changes to your information can be made by logging into your account at www.discoverybenefits.com

Step 2: Reimbursement Information

Step 2a: Claim Information

Note: If you filed the claim online, please do not complete this form. Simply upload the supporting documentation online or fax the confirmation page and supporting documentation to 1-866-451-3245.

*Plan Type	*Date(s) Expense(s) Incurred	*Merchant/Provider Name	*Name of Person Receiving Product/Service	*Claim Amount
				\$
				\$
				\$
				\$
			*Total Reimbursement Requested	\$

*Plan Types: **MSA**-Medical Spending Account; **DCA**-Dependent Care Account; **LMSA**-Limited Medical Spending Account; **EMSA**-Employer Funded Medical Spending Account; **EDCA**-Employer Funded Dependent Care; **HRA**-Health Reimbursement Arrangement; **RMSA**-Retiree Medical Savings/Spending Account; **IPA**-Individual Premium Account

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your dependent care provider must complete Step 2b.

Step 2b: Dependent Care Provider Signature and Certification (for dependent care claims only)

I certify the information provided is accurate.

*Dependent Care Provider Signature

Step 3: Participant Certification

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Dependent Care Account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. By submitting this form I certify the above.

I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

