



P. O. Box 4346
Missoula, MT 59806

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)
REIMBURSEMENT REQUEST

To send scanned claims, or for additional forms, go to:
https://www.askallegiance.com/

FAX: 406-523-3149 or toll-free 877-424-3539 PHONE: toll-free 877-778-8600

Please print legibly in black or blue ink.

Employer Name: \_\_\_\_\_ Total # of Pages Submitted: \_\_\_\_\_
Employee Name: \_\_\_\_\_ Attention: \_\_\_\_\_
Participant ID: \_\_\_\_\_ Comments: \_\_\_\_\_
(Social Security Number or, if assigned, Allegiance ID)
You may check the status of your claim, within 48 hours, by logging in to your account at
www.allegianceflexadvantage.com. If you have not received reimbursement within two weeks, please contact an
Allegiance representative at 877-778-8600.
If you would like future payments directly deposited into your bank account, include a voided check with
this form or sign up on the Allegiance website.

PLEASE SEE REVERSE FOR CLAIM FILING INSTRUCTIONS. List the medical, dental or vision services and expenses for
you and your family that you have to pay after insurance pays its share. Insurance premiums are not eligible.

Table with 3 columns: TYPE OF EXPENSE, SERVICE DATES, AMOUNT REQUESTED. Rows include Medical, Prescription, Vision, Dental, and Orthodontia Reimbursement Requested, and a TOTAL REIMBURSEMENT REQUESTED row.

Include independent, third-party documentation of your expenses with this claim form. If any of these expenses were covered by insurance, attach a copy of
the explanation of benefits (EOB) from your insurance company. For expenses that are not eligible for submission to insurance, send a copy of a bill or
invoice identifying the service, service date, and total charges. If required documentation is not attached, your reimbursement may be delayed.

I certify that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my qualified dependents,
and/or spouse. These expenses have not previously been reimbursed under any plan and I will not seek reimbursement under any other health plan. I
understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed through my health
FSA may not be claimed on my individual tax return.

Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_

Check here if your address has changed. New address: \_\_\_\_\_
Please inform your employer if your address has changed.

\*\*\*Over-the-counter drugs and medicines are not reimbursable unless prescribed by a medical practitioner.

## **FILING A CLAIM**

Please read these important reminders for quick and efficient reimbursement:

- Please make sure to fill out your form completely (employer, ID#, your name). Documentation must include service dates, service description and charges for services received.
- Combine all like reimbursement requests. For example, If you are submitting several prescription receipts for reimbursement, enter the range of dates over which the purchases were made and the total of all the receipts on the prescription line:

**Prescription Reimbursement Request    From: 7/1/13    To: 7/31/13    \$145.78**

- Service dates must be within the plan year to be eligible expenses. If your employment terminates during the plan year, service dates must be within the plan year **and** while you were an active participant in the plan (ie: eligible and making contributions).
- If the service is eligible for insurance, an explanation of benefits must accompany the claim form, unless the bill from the provider shows the amount that insurance has paid, or the receipt is clearly a co-pay amount. **Bills from providers that estimate insurance payment will not be reimbursed.**
- If the reimbursement requested is not eligible for submission to insurance for reimbursement consideration, a bill or receipt showing date, service and charges is adequate documentation of the expense, as long as there is no reference to insurance coverage on the bill or receipt.

Eligible claims received must total at least \$1.00 before a check will be mailed or an electronic deposit initiated by Allegiance.

Save time! Direct deposit is a convenient and easy way to receive your flex reimbursement- see <https://www.askallegiance.com/> and sign up today!