



Mail to: P.O. Box 840, Honolulu, HI 96808-0840
 Phone: (808) 538-8900 Toll-free (800) 490-3956
 Fax: (808) 538-8930

Company _____



View your account balance on-line at www.bshi.net

**Health Reimbursement Arrangement
 REIMBURSEMENT REQUEST FORM**

Name (Last, First, M.I.)	Employee ID or SSN	Email Address
Mailing Address		Daytime Phone Number

Attach **PHOTOCOPIES** of appropriate statements, receipts and/or documents to this request form. Reimbursement is based on when you receive services and not when you paid for the expense. Expenses from a different plan year must be on a separate form. Incomplete requests or expenses that are not itemized below will be returned to you to complete and resubmit.

BEFORE SUBMITTING YOUR REQUEST, MAKE A COPY OF THIS REQUEST FORM AND KEEP YOUR ORIGINAL DOCUMENTATION FOR YOUR RECORDS.

Please make sure you review the reimbursement guidelines on the back of this form and your HRA information sheet before completing this form.

MEDICAL EXPENSE/HEALTH REIMBURSEMENT ARRANGEMENT _____

Date of Service	Description of Service	Name of Provider	Name of Person Receiving Service	Relationship (Self, spouse, or dependent)	Your out-of-pocket cost
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
TOTAL					\$ 0.00

I certify that the expenses listed above have been incurred by me, my spouse, and/or my eligible dependents for reimbursements. These expenses have not been previously submitted for reimbursement to this or any other health reimbursement arrangement account. I affirm that expenses shown are reimbursable under IRS regulations and are not reimbursable under any insurance plan.

I have read and understand the reimbursement guidelines printed on the back of this form and on the HRA information sheet.

Participant's Signature

Date

Deadline for claims submission

You have until March 31st following the close of the Plan Year to submit a request for reimbursement. However, it is recommended that requests be submitted well before March 31st in the event that there is a discrepancy with your request. Requests must be in our office by March 31st.

Reimbursement Guidelines

1. To avoid delays in reimbursement, dates of service must be clearly itemized with your out-of-pocket expense indicated on your documentation. Requests that are not itemized will not be processed and will be returned to you.
2. Services claimed for reimbursement must be received during your plan year.
3. Reimbursement is based on the date of service and not the date that the service was paid for.

In accordance with IRS guidelines, BSH will not accept the following types of documentation for reimbursements

- Canceled checks, credit card receipts, or statements
- Cash register receipts (except for contact lens solution and over-the-counter items and parking fees for medical services)
- Receipts which do not include the following information for store purchases: date of purchase, name of store, item purchased, and amount paid
- Statements which do not indicate all of the following for services received: name of patient, date(s) of service, name of provider, service provided, and amount charged
- Receipts or statements indicating "paid receipt" or "prior balance"
- Receipts or statements for any non-qualifying expenses, even if prescribed by a medical doctor

Miscellaneous

For services or purchases not covered in this guideline, BSH will review the claims and documentation as specified by the IRS.

To ensure that your claim is processed in a timely manner, here is a list of the proper documentation for the most common expenses

Health / Dental / Vision Services

A bill or statement showing the name of the patient, name of the provider, date of service, description of service performed, and amount charged. A member report from the insurance carrier is the best form of documentation for these services.

Expenses payable to the provider by the insurance company are not reimbursable.

Prescription Drugs

Each receipt must show the name of the patient, name of the provider, date of purchase, name of the drug, and the amount paid. Some pharmacies do not automatically provide you with the necessary receipt for reimbursement documentation. Therefore, you'll need to ask the pharmacist for the appropriate receipt. Some prescribed medications, such as those for cosmetic purposes (e.g. weight loss and hair loss), are not reimbursable.

Massage / Shiatsu

According to IRS guidelines, a medical doctor must prescribe these therapy services. Documentation must include: medical condition being treated, duration of treatment, and frequency of treatment.

Contact Lens Solution and other Over-the-Counter Items

You may submit a cash register receipt, provided the receipt shows the name of the store, date of purchase, description of the item, and the amount paid.

Orthodontics

You may submit any orthodontic requests based on payments made to the orthodontist. We will reimburse up to your account balance based on either services or payments that are incurred during the plan year.

Medical / Dental / Long-Term Care Insurance Premiums

A bill or statement from the insurance carrier is acceptable if it shows the name of the insured, the type of coverage, and the premium amount. Premiums that are eligible for payment or reimbursement through a health flexible spending account or cafeteria plan under Section 125 of the Internal Revenue Code are not eligible for reimbursement under this HRA plan.