



# FLEXCOMP REIMBURSEMENT VOUCHER

Claim No. \_\_\_\_\_

Mail to: BSC Payroll Office, P. O. Box 5587, Bismarck, ND 58506-5587  
 Drop off or send internal mail to: Payroll Office, Room 101, Annex Building  
 Fax to: 701-224-2565

*Please follow claim filing instructions on the back of the voucher to avoid delays in claims processing.*

Section 1 Participant Information			
Plan Participant Name (Last, First, Middle)		Empl ID	Plan Year 2009
Address		City	State Zip
Office Phone	Email address		

Section 2 Medical Expenses (Attach Verification)					
Service Date (m/d/yyyy)	Provider Name	Amount	Service Date	Provider Name	Amount
<b>Total Medical Reimbursement Request: \$</b>					
Date Paid:	Amount Paid:	Amount Denied:			

Section 3 Dependent Care Expense (Attach Cost Verification)				
Name of Provider	Provider's Tax ID	Date of Expense		Amount
		From	Through	
<b>Total Dependent Care Reimbursement Request: \$</b>				
Date Paid:	Amount Paid:	Amount Denied:		

Section 4 Certification	
<p>The undersigned participant in the Plan certifies the following:</p> <ul style="list-style-type: none"> <li>- All expenses for which reimbursement is claimed by submission of this form were incurred during a period while the undersigned was a participant in the Plan.</li> <li>- The expenses were for services received by the participant or his/her dependent(s) as defined in the Plan.</li> <li>- The expenses have not been reimbursed and are not reimbursable under any other health plan coverage.</li> <li>- Any dependents for which the participant selected dependent care benefits reside in a parent/child relationship and/or are legally dependent on the participant for their support.</li> <li>- The undersigned fully understands that he or she alone is fully responsible for the accuracy of all information relating to this claim and that unless an expense for reimbursement is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state and FICA tax on amounts paid from the Plan which relate to such expense.</li> <li>- The undersigned agrees that the reimbursement associated with their dependent care reimbursement request is for dependent care expenses that have been incurred.</li> </ul> <p><b>I CERTIFY, UNDER PENALTIES OF PERJURY, THAT THE INFORMATION SUBMITTED ON THIS VOUCHER REQUEST AND ATTACHED BILLINGS AND RECEIPTS (or copies thereof) IS TRUE, CORRECT AND COMPLETE. I also understand that BSC, its agents or employees, will not be held liable if I submit a non-IRS eligible expense for reimbursement.</b></p>	
By _____	Date _____
Plan Participant's Signature	

**Claim Filing Instructions**  
**FlexComp Reimbursement Voucher**

In order for BSC to comply with the IRS requirement for claims substantiation, the following outlines the acceptable forms of documentation to submit in order to ensure your claim will be processed without delay:

- 1 A copy of the page of the Explanation of Benefits (EOB) that lists the breakdown of charges and benefits indicating the deductible, co-insurance, co-payment, etc. from your health, dental or vision insurance carrier. No other documentation is necessary if you submit the EOB. For prescription drugs, you will need to submit the Quarterly Prescription Drug Summary from your insurance carrier to receive reimbursement. Monthly pharmacy printouts will also be accepted. Please stay with either quarterly drug summary or printouts through the entire plan year.
- 2 If you do not have insurance coverage, a statement from the provider is required. The statement must include the provider's name, patient name, a fully itemized list of services received and the date-of-service(s). Statements with only a balance forward or balance due cannot be accepted.
- 3 Orthodontic expenses may be reimbursed on a monthly payment schedule as payment is required and paid. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. To be reimbursed for orthodontic expenses that will be incurred during the plan year, a copy of the contract or a statement from the provider must be submitted along with a receipt showing date and amount of payment.
- 4 OTC Claim Substantiation: A detailed cash register receipt must be submitted to substantiate your request which will need to include the name of the store/pharmacy, date-of-purchase, the name of the item(s). If the name of the item is NOT self-explanatory, please handwrite a note next to the item name on the detailed cash register receipt for the OTC (over-the-counter) item.
- 5 For Dependent Care claims your provider must complete the BSC Day Care Cost Verification with the following information:

Name of Provider  
Tax Identification number or Social Security Number  
Actual dates on which care was provided (not billing payment date)  
Amount of dependent care expense

Eligible Dependent Care Expenses

- Must be for the purpose of enabling you or you and your spouse to be employed.
- Must be for a child under 13 years of age who is your dependent under Federal tax laws.
- Must be provided by someone other than your spouse or another dependent child.

Ineligible Dependent Care Expenses: You cannot obtain reimbursement for the following:

- Food, transportation, registration or supply fees if they are billed separately from the dependent care expenses.
- Kindergarten expenses that are primarily education in nature, regardless of half or full-day, private or public school, state mandated or voluntary. However, if your day care provides kindergarten that is run on the order of a nursery school, with the child's education merely incidental to the care provided and the cost cannot be separated from the cost of the child care, the entire amount can be considered an eligible expense.

Dependent Care expenses that must be paid in advance cannot be reimbursed until the services have been rendered.

Services that require pre-payment cannot be reimbursed until after the services have been rendered.

***Voucher/Claims filed without the above documentation cannot be processed and will be returned.***

Mail completed voucher to: BSC Payroll Office, P. O. Box 5587, Bismarck, ND 58506-5587  
Drop off or send internal mail to: Payroll Office, Room 101, Annex Building  
Fax to: 701-224-2565

January 2009