PLACER COUNTY OFFICE OF EDUCATION

MEDICAL AND DEPENDENT CARE REIMBURSEMENT CLAIM FORM

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM
PLEASE PRINT LEGIBLY OR TYPE.

RETURN ORIGINAL OF COMPLETED FORM AND COPY OF RECEIPT(S) TO:
***Envoy Plan Services, Inc*.**
Corporate Office
23052-H Alicia Pkwy #605
Mission Viejo, CA 92692
Or Fax: 1-800-300-7313

EMPLOYEE INFORMATION

EMPLOYEE NAME	WORK PHONE NUMBER
MAILING ADDRESS CHECK HERE IF THIS IS A NEW ADDRESS ☐	HOME PHONE NUMBER
CITY STATE ZIP	CELL PHONE NUMBER
E-MAIL ADDRESS:	

Requests for reimbursement must total a minimum of $25, except at the end of the Plan Year. If a request is submitted for less than $25 during the Plan Year, the request will be held pending the submission of additional reimbursement requests.

EXPENSES TO BE REIMBURSED

MEDICAL REIMBURSEMENT ACCOUNT - Out-of-pocket health care expenses eligible for reimbursement

DESCRIPTION OF EXPENSE	RELATIONSHIP TO EMPLOYEE IF DEPENDENT RECEIVED SERVICES	DATE SERVICES INCURRED	AMOUNT OF CLAIM
			$
			$
			$
			$
Attach Copies of Receipts Supporting Each Item of Expense		**TOTAL**	$

If more lines are needed, you may use one claim form and attach an itemized listing on a separate sheet of paper

DEPENDENT CARE REIMBURSEMENT ACCOUNT - Dependent care expenses eligible for reimbursement

NAME OF DEPENDENT CARE PROVIDER	FEDERAL ID # OR SOCIAL SECURITY # OF CARE PROVIDER	NAME & RELATIONSHIP OF DEPENDENT	AGE OF DEP.	DATES OF SERVICE		AMOUNT OF CLAIM
				FROM (MO/DAY/YR)	TO (MO/DAY/YR)	
						$
						$
						$
						$
Attach Copies of Receipts Supporting Each Listed Item					**TOTAL**	$

EMPLOYEE STATEMENT – READ CAREFULLY

I certify that I am familiar with and understand the Plan provisions and requirements and that all expenses for which reimbursement or payment are claimed by submission of this form were incurred during the period while I was covered under the Plan. **IRS regards the date incurred as being when the service is rendered, not when you actually pay the bill.** I also certify that amounts claimed are not eligible for payment under any health care plan or program, federal, state or government plan, workers' compensation, or any other policy of health insurance. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and validity of all information relating to this claim that is provided by me. I further understand that no medical and dental expenses tax deduction or Child & Dependent Care tax credit is permitted for amounts for which reimbursement is made through this Plan.

EMPLOYEE SIGNATURE	DATE

RETAIN THE ORIGINAL RECEIPT(S) AND A COPY OF THIS FORM FOR YOUR RECORDS – **SEPARATE FORMS MUST BE USED FOR DIFFERENT PLAN YEARS**

- **All requested information on this claim form must be provided, including receipts, your signature and the date. Failure to do so will result in a delay in processing your claim.**
- To request reimbursement, a copy of a statement, bill, or receipt from your service provider(s), showing the services received, must be attached. This statement must clearly identify the service provided, date on which the service was provided (not date you paid for it), and the amount of the expense. Please send legible copies; your original statements, bills, or receipts should be retained by you.
- **Copies of cancelled checks or credit card receipts will not be accepted as the sole substantiation of documenting expenses incurred.**
- **Services must have been incurred to receive reimbursement. You may not request reimbursement until you have received the service, regardless of when you pay for it.**
- According to IRS Regulations and your Plan Document, up to $550.00 of unused contributions in your Medical Expense Reimbursement Account may be carried over to the next Plan Year. This feature does NOT apply to your Dependent Care Spending Account.
- If a service is provided during your current period of coverage and will continue to be provided in a subsequent Plan Year, you will not receive reimbursement for the services you received in the subsequent plan year unless you re-enroll in the account(s) and submit a separate reimbursement claim form for that period.
- Requests for reimbursement must total at least $25, except at the end of the Plan Year, at which time the request may be for less than $25.
- You have 90 days following the end of the Plan Year (June 30th) to submit claims for reimbursement for services incurred during the Plan Year. Reimbursement claims not postmarked by September 30th will be rejected. **Corrections to claims received after September 30th will not be accepted. Please insure all claims including itemized receipts are submitted by September 30.**

For more information regarding eligible expenses, visit our website at www.EnvoyPlanServices.com and click on Bulletins & Links

Additional Medical Expense Reimbursement Instructions

Medical Expense Reimbursement claims must be submitted with copies of a statement, bill, or receipt from your service provider(s) showing:
Service received, who received it, when it was received, insurance portion and the cost. You may submit copies of the "Explanation of Benefits" form issued to you by your insurer or that of your spouse.

Prescription Drugs: You must supply prescription name, date and Rx number and amount paid for reimbursement of prescription costs. The Rx stub is sufficient.

Orthodontia: Orthodontia procedures, which are not primarily for cosmetic reasons, are eligible for reimbursement. However, you will be required to submit a contract from your orthodontist with your first claim for reimbursement, indicating that the services are not for cosmetic reasons.

Expenses for "cosmetic reasons" are ineligible for reimbursement if the services do not promote proper function of the body or are not designed to treat, prevent, cure or mitigate a specific medical condition as defined by IRS regulations. A letter from your health care provider indicating services are medically necessary must be submitted with this claim form if the services are generally considered cosmetic in nature, i.e., weight loss programs.

Insurance premiums for health, dental, accident or long-term care coverage are not eligible for reimbursement.

The maximum amount of your claim for eligible medical expenses is the amount indicated on your Enrollment Form, less any prior reimbursements.

Additional Dependent Care Reimbursement Instructions

According to the IRS regulations, Dependent Care Reimbursement claims cannot be processed without receipts signed by the provider showing the name, address, beginning and ending dates of service, and the amount of expense. You must provide the tax I.D. (or social security) number of the provider(s) on this claim form or the receipt.

The IRS requires that you incur and complete the service for the period of your Dependent Care expenses before you can be reimbursed.

The maximum amount of your claim for Dependent Care expenses is the amount remaining in your Dependent Care spending account.

Under a Dependent Care Reimbursement Account, a qualified dependent is your dependent under age 13 or your dependent or spouse who is physically or mentally incapable of self-care. According to the IRS, physical or mental incapacity is not being able to dress, clean, or feed oneself.

Payments for Dependent Care cannot be made to someone you or your spouse claim as a dependent and, if the person you make payments to is your child, he or she must have been age 19 or older by the end of the plan year.

Dependent Care expenses while you are on leave from work (sick, vacation, etc.) or during periods of no work (school breaks) are not considered eligible expenses.

Generally, the cost of kindergarten is not eligible for reimbursement.

For questions please contact us by e-mail or phone:
Phone: 1-800-248-8858, Ext. 5252 • Fax 1-800-300-7313
E-mail: 125@envoyplanservices.com

For reimbursement, mail or fax this claim form, along with copies of your supporting documentation to:

***Envoy Plan Services, Inc*.**
Corporate Office
23052-H Alicia Pkwy #605
Mission Viejo, CA 92692
FAX: 1-800-300-7313

Right to Appeal
If your claim is denied or not paid in the full amount requested, you have a right to appeal the decision. Please follow the steps below:
- Call 1-800-248-8858, and ask for an explanation.
- If you are still not satisfied with the decision, you have 60 days from the date you received written notification to write a letter to the Director of Business Services, 360 Nevada Street, Auburn, CA 95603. State the reasons you feel the decision was incorrect, attach a copy of the Reimbursement Claim Form and present any additional information.
  You will receive a response in writing to your appeal generally within 60 days. The Director's and/or Plan Administra