



CLAIM FORM – FLEXIBLE SPENDING ACCOUNT

ANSWER ALL QUESTIONS FULLY, ATTACH BILLING/RECEIPT/EXPLANATION OF BENEFITS (EOB), AND FAX TO BAC AT (614) 863-0184, OR MAIL TO PO BOX 107, REYNOLDSBURG, OH 43068-0107

A. STATEMENT OF PARTICIPANT: PLEASE ANSWER ALL QUESTIONS FULLY

EMPLOYERS NAME:			
EMPLOYEE NAME (LAST, FIRST, M.):		SOCIAL SECURITY NUMBER:	
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	DATE OF BIRTH (MM/DD/YYYY):	EMAIL ADDRESS:	IS THIS A NEW ADDRESS?:

B. QUALIFIED TAX-FREE REIMBURSEMENT (SEE REVERSE): ATTACH DETAILED BILLING/RECEIPT AND/OR AN EOB

1.	CLAIMANT:	DATE:	AMOUNT:
	PROVIDER OF SERVICE (NAME OF DOCTOR, DENTIST, OR OTHER):		
2.	CLAIMANT:	DATE:	AMOUNT:
	PROVIDER OF SERVICE (NAME OF DOCTOR, DENTIST, OR OTHER):		
3.	CLAIMANT:	DATE:	AMOUNT:
	PROVIDER OF SERVICE (NAME OF DOCTOR, DENTIST, OR OTHER):		
4.	CLAIMANT:	DATE:	AMOUNT:
	PROVIDER OF SERVICE (NAME OF DOCTOR, DENTIST, OR OTHER):		

TO BE ELIGIBLE FOR REIMBURSEMENT YOU MUST: INCUR THE EXPENSE AS AN ACTIVE PARTICIPANT DURING THE CURRENT PLAN YEAR, AND SUBMIT THE PROVIDER BILL TO BAC WITH CLAIM FORM ATTACHED. SOME PLANS ALLOW FOR A GRACE PERIOD OF UP TO A 2 1/2 MONTH CARRY OVER OF UNUSED FUNDS AT THE END OF THE PLAN YEAR. PLEASE CHECK YOUR CAFETERIA PLAN DOCUMENT TO DETERMINE IF THIS PROVISION WILL APPLY TO YOUR PLAN. FOR FLEXIBLE SPENDING ACCOUNT EXPENSES, PLEASE MAKE SURE YOUR PROVIDER BILL IDENTIFIES THE PATIENT, THE PROVIDER AND THE DATE OF SERVICE.

C. REIMBURSEMENTS:

BAC WILL REIMBURSE FOR CLAIMS SUBMITTED VIA CHECK OR DIRECT DEPOSIT ACCORDING TO THE PARTICIPANT'S CHOICE ON THE CAFETERIA PLAN ELECTION FORM. TO CHANGE THE METHOD OF REIMBURSEMENT, PLEASE SUBMIT A DIRECT DEPOSIT AUTHORIZATION/CHANGE FORM FOUND ON BAC'S WEBSITE.

D. AUTHORIZATION:

THE EXPENSES SUBMITTED FOR PAYMENT HAVE NOT BEEN REIMBURSED AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE OR BY ANY OTHER FORM OF REIMBURSEMENT

X _____
EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): DATE SIGNED (MM/DD/YYYY):

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

E. INSTRUCTIONS:

ELIGIBLE HEALTH CARE EXPENSES:

In general, an employee may be reimbursed for a health care expense which qualifies as a deduction on the Federal Income Tax return, (Section 213 Expenses) but which has not or will not be reimbursed by any other source and has not been or will not be deducted on the employee's income tax return. (See examples below)

SUPPORTING DOCUMENTATION (For Eligible Health Care Expenses)

The following supporting documentation must be attached to your claim form:

- MEDICAL EXPENSES COVERED UNDER ANY HEALTH BENEFIT PLAN MUST FIRST BE SUBMITTED TO THAT PLAN FOR PAYMENT**, before you may apply for reimbursement through your Flexible Spending Account. After you have filed with the other plan, attach a copy of their Explanation of Benefits statement (EOB) so that you may be reimbursed for the out-of-pocket expenses not paid by the other health benefit plan.
- IF YOUR HEALTH BENEFIT PLAN OR YOUR SPOUSE'S HEALTH BENEFIT PLAN IS ADMINISTERED BY BAC**, please submit a completed Flex Claim Form along with your regular claim submission. This will enable BAC to reimburse you through your Flexible Spending Account, for out-of-pocket expenses not paid by the Health Benefit Plan.
- OVER-THE-COUNTER EXPENSES**, attach original cash register receipt that clearly states name of drug, date of purchase, and name of pharmacy where purchased.
- FOR ALL OTHER EXPENSES**, attach bills that clearly state:
 - name of person receiving service
 - nature of service or supplies
 - name and address of provider of service
 - amount charged
 - date of service

*** This is only a summary in outline form of the benefits and rules of the Plan. Eligible persons who choose to participate should review the PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION (Benefit Booklet) for information about; participation, benefits, year end timely filing limitations and other limitations and exclusions. This is not a contract, policy or guarantee of coverage. ***

HOW TO FILE CLAIMS:

- Mail a copy of the claim along with this claim form to BAC at P. O. Box 107 Reynoldsburg, Ohio 43068, or fax to BAC at (614) 863-0814
- Email a scanned image of the claim along with this claim form to flexclaims@bactpa.com
- If your plan allows for access to the BAC Members' Area and you are requesting payment on the balance of a claim which BAC processed you may submit your request directly from your secure members area
 - www.bactpa.com and select "participant" from the members area, complete your secure log on (if you have never logged in you will need to complete the FIRST TIME USERS LOG IN)
 - Choose "Claims" under the left hand menu bar
 - Click on the ! next to the members name for whom the claims were processed
 - Click on "Details" button next to the claim you want to submit
 - Click on the EMAIL button in the center of the page – this will launch a separate window with the claim information attached
 - In the text box at the bottom of the new window please request the amount of this claim that you want to be reimbursed to you from your flex account. It is also IMPORTANT that you indicate if you have other coverage that will pay a portion of this claim. **If you do not have any other coverage for this claim please state "no other coverage is applicable to this claim".**

A QUALIFIED MEDICAL EXPENSE AS DESCRIBED IN SECTION 213 OF THE INTERNAL REVENUE CODE IS BROADER THAN WHAT IS COVERED UNDER A TYPICAL MEDICAL, DENTAL, OR VISION PLAN.

EXAMPLES INCLUDE:

- Medical, dental, and vision expenses not covered by insurance or other plans
- Alcoholism and drug addiction treatment
- Fertility and sterilization treatments
- Nursing home and certain long-term care services
- Travel expenses (mileage, parking, lodging, etc.) necessary to receive medical care
- Special controls, equipment, or improvements to accommodate a disabled family member
- Laser eye surgery, contact lenses, and cleaning solutions
- Dentures, orthodontics, including braces
- Hearing tests, hearing aids, and batteries
- Bandages, canes, crutches, and wheelchairs
- Over-the-counter drugs (non-prescription) **Includes:** headache and cold medicines, antacids, topical pain remedies, cough drops, etc.

NOT COVERED ARE NON-QUALIFIED MEDICAL EXPENSES.

EXAMPLES INCLUDE:

- Cosmetic surgery and procedures unless needed to correct deformity due to an accident, illness, or birth defect
- Health club membership
- Weight loss unless prescribed by a physician and related to a specific diagnosis
- Vitamins and nutritional supplements
- Bottled water and hygiene products
- Hair transplants and hair removal
- Domestic help or diaper services

**MAIL COMPLETED FORM TO:
BAC, PO BOX 107
REYNOLDSBURG, OH 43068**

**OR FAX COMPLETED FORM
TO BAC AT:
(614) 863-0184**

**OR SUBMIT YOUR FLEX CLAIM
ONLINE BY FOLLOWING THE
INSTRUCTIONS ABOVE**