Health Care Reimbursement Account Request

A. INSTRUCTIONS

- COMPLETE SECTIONS B, C, AND D
- IF EXPENSE IS COVERED BY INSURANCE, SUBMIT TO APPROPRIATE CARRIER
- ATTACH EXPLANATION OF BENEFITS (EOB) FROM THE INSURANCE CARRIER OR CO-PAY RECEIPTS
- IF YOU ARE SUBMITTING AN ITEMIZED BILL ONLY, INDICATE WHY THIS BILL HAS NOT BEEN PAID BY YOUR INSURANCE PLAN (SPACE PROVIDED ON REVERSE OF THIS FORM)
- ITEMIZED BILLS SHOULD INCLUDE THE FOLLOWING:
  - PROVIDER NAME AND ADDRESS
  - PATIENT NAME
  - ITEMIZED CHARGES
  - DATE OF SERVICE
  - TYPE OF SERVICE
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS, AND BALANCE DUE BILLS ARE **NOT ACCEPTABLE** PROOF OF EXPENSES
- IF YOU HAVE ANY QUESTIONS, PLEASE CALL: 800.242.2269
- FOR GENERAL INFORMATION/CLAIM FORMS, VISIT OUR WEBSITE: **www.cigna.com/fsa**
- MAIL COMPLETED FORM ALONG WITH APPROPRIATE DOCUMENTATION TO: **CIGNA REIMBURSEMENT ACCOUNTS**
  P.O. BOX 0976
  BRISTOL, CT 06010

B. EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY NUMBER	COMPANY NAME	ACCOUNT NUMBER(S)
	Brookhaven Science Associates, LLC	**2258277**

LAST NAME	FIRST NAME

ADDRESS	CITY	STATE	ZIP CODE

C. HEALTH CARE EXPENSES

PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE:

DENTAL COVERAGE? ☐ YES* ☐ NO
MEDICAL COVERAGE? ☐ YES* ☐ NO
VISION COVERAGE? ☐ YES* ☐ NO

* IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.

PATIENT NAME	PROVIDER (I.E., DOCTOR NAME/ PHARMACY NAME)	DATE(S) OF SERVICE	TOTAL CHARGE A.	AMOUNT PAID BY OTHER SOURCES B.	AMOUNT TO BE REIMBURSED (A - B = C)
	TOTAL REIMBURSEMENT REQUEST: $ _____				

D. CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- **They were incurred for services or supplies by me or my eligible dependents under the plan.**
- **They were for services or supplies furnished on or after the effective date of my employee spending account.**
- **I have not been reimbursed for these expenses in any other way.**

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

EMPLOYEE SIGNATURE *(Required)*	DATE

ADDITIONAL INFORMATION

(If applicable, please use this space to explain why this bill is not being paid by your insurance plan.)