

**Battelle Flexible Reimbursement
Account Claim Form - 2004**

(Please Print)

SECTION A: STAFF MEMBER INFORMATION				
SOCIAL SECURITY NUMBER:	LAST NAME:	FIRST NAME:	MI	COMPONENT <input type="checkbox"/> BCO <input type="checkbox"/> PNWD
OFFICE LOCATION/ROOM NO.:		OFFICE TELEPHONE NO.: () -		
EMPLOYEE'S HEALTH PLAN:		TYPE (i.e., Single, Family):		
SPOUSE'S HEALTH PLAN (if different, or additional coverage):		TYPE (i.e., Single, Family):		
ANY OTHER HEALTH PLAN:		TYPE (i.e., Single, Family):		

SECTION B: CLAIM INFORMATION*

**Please note: Due to federal law, medical costs incurred by registered domestic partners (RDPs) are not reimbursable under the FRA. However, medical and daycare costs incurred by dependents of the RDP are considered reimbursable as long as they meet the definition of an eligible dependent of the staff member.*

1. HEALTH CARE EXPENSE (Please group all "like" expenses together) PROVIDER OF SERVICE	TYPE OF SERVICE (Medical, Dental, Vision, Hearing)	INCLUSIVE DATES OF SERVICE (MO/DAY/YR)	UNREIMBURSED BALANCE BEING CLAIMED
Medical Expenses and Prescriptions	M		\$
Dental Expenses	D		\$
Vision Expenses	V		\$
Hearing Expenses	H		\$
Over the Counter Drugs	M		\$
TOTAL HEALTH CARE REIMBURSEMENT REQUESTED			\$

2. DEPENDENT DAYCARE EXPENSE (Daycare receipts must contain the information described on the reverse side of this form.)**					
PROVIDER OF CARE	DEPENDENT	AGE	RELATIONSHIP	DATES OF SERVICE TO/FROM	AMOUNT OF CLAIM
					\$
					\$
					\$
					\$
TOTAL DEPENDENT DAYCARE REIMBURSEMENT REQUESTED					\$

**According to IRS, to establish "due diligence," you are required to maintain information included on Form W-10.

SECTION C: STAFF MEMBER CERTIFICATION

I request payment from the Flexible Reimbursement Plan for the expenses itemized above. I have included supporting documentation from any plan that provides benefits for any expense eligible under this account. **I certify that I have not previously requested reimbursement under this Plan nor have I received nor will I seek reimbursement from any other source for the expenses now claimed.** I certify that the total dependent daycare expenses (if any) for which I am requesting reimbursement for this plan year do not exceed the lesser of my own or my spouse's earned income for the year. The expenses being reimbursed are for the care of a "qualifying" individual for whom the supplemental earned income credit will not be claimed for the year of the reimbursement. I further certify that I have met all the requirements for eligible health care and dependent daycare expenses as described in the Plan (summarized on the reverse side of this form). I understand that **reimbursed expenses cannot be claimed on my personal income tax return** and that Battelle is not responsible for any penalties, interest, or back taxes should expenses be judged by the Internal Revenue Service to be ineligible.

STAFF MEMBER SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY: Rec'd by/Init. _____ Processed _____ Approval to Pay _____

Send claims to FRA MS K1-34/ROB Rm. 1260 or to Columbus, Benefits Finance Room A-197

IMPORTANT INFORMATION REGARDING FLEXIBLE REIMBURSEMENT ACCOUNT (FRA)

GENERAL INFORMATION

1. Claims for the current plan year must be submitted separately from claims for the previous plan year. Claims, **which are supported with proper documentation**, are due to the PNNL Benefits office on the **2nd to last** working day of the month and in the Columbus Benefits Office on the **last** working day. Reimbursement checks are cut on the 15th of the **next** month. **FRA claims are based on date of service not date of payment.** FRA can only reimburse actual out-of-pocket expenses after all other reimbursements.
2. Federal law requires that any balance not fully used for reimbursement of eligible expenses incurred within each plan year be forfeited. Claims cannot be submitted for expenses incurred prior to your enrollment in the FRA.
3. Money cannot be transferred between accounts.
4. All claims for the current plan year must be received with proper documentation by the following June 30 or dollars will be forfeited.
5. Requests for claim forms and additional information regarding the Plan and your account should be directed to your component Benefits Administration Office. Forms may also be obtained by going online to <http://hr.pnl.gov/benefits/html/formsplan.htm> or www.battelle.org/benefits/forms.htm.
6. Submit completed claim forms to the Benefits Office, MS K1-34 or directly to Columbus via Pouch Mail at Benefits Finance, Room A-197. Retain copies of all claims and supporting documentation for your personal records.
7. Due to federal law, medical costs incurred by registered domestic partners (RDPs) are not reimbursable under the FRA. However, medical and daycare costs incurred by dependents of the RDP are considered reimbursable as long as the dependent meets the definition of an eligible dependent of the staff member.

HEALTH CARE EXPENSES

1. You may be reimbursed up to your total annual commitment minus any prior reimbursements for **certain** unreimbursed health care expenses that could otherwise be itemized on your federal income tax return.
2. Examples of qualifying and non-qualifying expenses and an explanation of governing tax rules are contained in Internal Revenue Service Publication 502 or by accessing the intranet at <http://hr.pnl.gov/benefits/html/healthcare.htm> or <http://www.battelle.org> (then click "Benefits"). Information can also be obtained from your component Benefits Administration Office at 509/375-6361 or by calling the FRA Coordinator at 614/424-5260.
3. Expenses covered by any medical or dental plan must first be processed by that plan(s) and copies of the Explanation of Benefits (EOB) Worksheets must be submitted with this form. If coverage is provided by two or more plans, copies of all EOBs must be submitted in order to claim any unreimbursed expenses. **Provider office visit co-pay receipts** may NOT serve as documentation. **Deductible expenses** cannot be documented by an EOB that says your deductible has been "met" – all corresponding EOBs must be submitted. **Mail Order Prescription** claims must be supported by the Statement of Benefits Account (SOBA) invoice enclosed with your prescription order.
4. Orthodontia: The following documentation must be submitted **each time** a claim is submitted:
 - An EOB that states what was paid by insurance, or states that maximums have been reached.
 - Once the maximum has been reached, a copy of the original payment agreement/contract with your orthodontist showing the total cost, terms, and date services began.
5. For expenses "above reasonable and customary" or those identified as "routine care," the EOB is sufficient documentation. All other health expenses, such as vision and hearing costs, over-the-counter drug purchases, or "excluded" or "ineligible" amounts not otherwise explained on the EOB **must** be supported by bills that state: provider of service (name and address); person receiving services; type of service or supply; amount of charge for service or supply; and date of service (including year).
6. Certain qualified expenses not covered by your Battelle medical or dental plan (e.g., prenatal vitamins, birth control pills, custodial care, etc.), can be submitted for reimbursement without first having an insurance denial.

DEPENDENT DAYCARE EXPENSES

1. The annual amount submitted for reimbursement cannot exceed the annual earned income of the lower paid spouse or \$2,500, if married filing separately. Reimbursement is limited to your actual account balance minus any prior reimbursements.
2. Expenses for the care of your dependent(s) must be incurred so that you or your spouse/RDP can work, look for work, or attend school full-time. Expenses must be incurred for the care of persons who are under age 13 for whom you are entitled to a dependent deduction under Internal Revenue Service Code Section 151(c) or a dependent who is physically or mentally incapable of caring for him or herself. The services cannot be provided by a person you claim as a dependent.
3. Complete definitions of dependents and eligible expenses for dependent daycare are outlined in IRS regulations. Expenses must meet the regulations and **a receipt must be submitted with this form including dates of service (including year), provider of service (name, address, Social Security number or taxpayer identification number), who paid for the service, the cost, service description (daycare), and provider signature.** Sample receipts for your use are available from your component Benefits Administration.