

Completion Guide

*Please be advised missing information may result in the denial or delay of your request.
Do not highlight documentation as highlighted sections become unreadable in our imaging software.*

Step 1: Participant Information

- **Email address:** Include an email address if you prefer receiving notifications electronically or if your email address has changed.

Step 2: Reimbursement Information

- **Plan Type:** Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Did You File Online:** If a claim was filed online at www.discoverybenefits.com, mark "Y" for yes. If not, mark "N" for no.
- **Date(s) Expense(s) Incurred:** Provide the date or range of dates the expenses were incurred.
- **Merchant/Provider Name:** Provide the name of the merchant or facility where the expense was incurred.
- **Name of Person Receiving Product/Service:** Provide your name or the name of the tax dependent for which the service was provided or the product was purchased.
- **Claim Amount:** Provide the total amount requested for the specified expense.
- **Total Reimbursement Requested:** Total the amounts in the "Claim Amount" boxes.

Step 2a: Dependent Care Provider Signature and Certification

- Should the day care provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Step 3: Participant Certification

- Sign and date the form after reading the Participant Certification.

Submit the completed form with the supporting documentation to Discovery Benefits!

Send your claim to:

Mail: PO Box 2926; Fargo, ND 58108-2926

Fax: 1-866-451-3245

Documentation Requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third party receipt containing the following information (please be advised if a receipt is unavailable a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

Reimbursement Request Form



This form is for reimbursement of any out-of-pocket expenses. Documentation to substantiate purchases made with your Discovery Benefits debit card must be submitted with a copy of a Receipt Reminder or a Receipt and Substantiation Form.

Step 1: Participant Information

*=Required Fields

<input type="text"/> *Employer Name (Do not abbreviate)		<input type="text"/> *Employee ID	
<input type="text"/> *Participant Name (First, MI, Last)		<input type="text"/> - <input type="text"/> - <input type="text"/> *Social Security Number	
<input type="text"/> Changes Only Participant Mailing Address (For changes/updates only)		<input type="text"/> Changes Only Email Address (If provided, all notifications will be sent via email)	
<input type="text"/> City	<input type="text"/> State	<input type="text"/> Zip	

Step 2: Reimbursement Information

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your day care provider must complete **Step 2a**. If you would prefer to only file one claim for the plan year, please visit www.discoverybenefits.com for our Automatic Dependent Care Request Form.

Plan Type	*Did You File Online (Y or N)	*Date(s) Expense(s) Incurred	*Merchant/Provider Name	*Name of Person Receiving Product/Service	*Claim Amount
					\$
					\$
					\$
					\$
*Plan Types MSA-Medical Spending Account; DCA-Dependent Care Account; LMSA-Limited Medical Spending Account EMSA-Employer Funded Medical Spending Account; EDCA-Employer Funded Dependent Care HRA-Health Reimbursement Account; TRN-Transportation; PRK-Parking; BIC-Bicycle RMSA-Retiree Medical Savings/Spending Account; IPA-Individual Premium Account					*Total Reimbursement Requested =

Step 2a: Dependent Care Provider Signature and Certification (for dependent care claims)

I certify the information provided above is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

*Provider Signature

Step 3: Participant Certification

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Dependent Care Account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. Further, I understand when submitting expenses for my Transportation or Parking Benefit, I can only claim incurred expenses for the purpose of commuting to and from work or parking at the employer from which the Transportation or Parking benefits are being offered. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. By submitting this form I certify the above.

I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

Participant Signature

Date