HEALTH REIMBURSEMENT ACCOUNT (HRA):
REQUEST FOR MEDICAL EXPENSE REIMBURSEMENT FORM

Submit your completed form and all claim documentation (Include copies of ALL receipts and documentation) to Benefit Coordinators Corporation (BCC):

For the fastest reimbursement and trackable progress, submit your claims through BCC's My SmartCare:

- Mobile App
  (download from your iOS or Android app store)
- Online Portal
  www.mywealthcareonline.com/bccsmartcare

Additional Submission Methods:

- Mail: Benefit Coordinators Corporation, Attn: FSA
  Two Robinson Plaza, Ste. 200, Pittsburgh, PA 15205
- Fax: 412-276-7185
- E-Mail: fsa-claims@benxcel.com *(PDF Files only, 5MB or less)*
- Download: https://secure.benxcel.com

Managing your reimbursement account has never been easier! For instant access to your account, register with My SmartCare's online portal at https://www.mywealthcareonline.com/bccsmartcare/ or download the free My SmartCare mobile app from your Apple or Android device.

EMPLOYER NAME:	**GROUP NUMBER:**
EMPLOYEE NAME:	**EMPLOYEE MEDICAL ID NUMBER:**
PATIENT NAME:	**NUMBER OF PAGES** (including receipts):
EMPLOYEE ADDRESS: ☐ *Please check if this is a change in address since you last submitted a claim.*	
STREET ADDRESS:	
CITY:	**STATE:** **ZIP:**
EMPLOYEE EMAIL ADDRESS:	**EMPLOYEE PHONE NUMBER:**

EXPENSES INCURRED

DATE OF SERVICE (MM/DD/YYYY)	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	RECIPIENT OF SERVICE	RELATIONSHIP TO EMPLOYEE	NET AMOUNT
					$
					$
					$
					$
					$
				TOTAL REIMBURSEMENT REQUESTED:	**$**

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan, and will not be claimed as an income tax deduction. I authorize my Account to be reduced by the amount requested.

EMPLOYEE SIGNATURE (Required) ______________________ DATE ______________________