Health Flexible Spending Account (FSA) Reimbursement Request

Allegiance® a Cigna Company

To send scanned claims, or for additional forms, go to: ***www.askallegiance.com***

Please print legibly in black or blue ink.

Employer Name:	Total Number of Pages Submitted:
Employee Name:	Attention:
Participant ID: *(Social Security Number or, if assigned, Allegiance ID)*	Comments:

Faxed and mailed claims may take longer to process than electronic claims and will not appear in your account until reimbursement occurs. For quick and easy processing, please login online to submit your claim. If you have not received reimbursement within two weeks, please contact an Allegiance representative at 877-424-3570.

To receive reimbursement faster sign up for direct deposit online.

PLEASE SEE REVERSE FOR CLAIM FILING INSTRUCTIONS.
List the medical, dental or vision services and expenses for you and your family that you have to pay after insurance pays its share. Insurance premiums are not eligible.

Type of Expense	Service Dates		Amount Requested
Medical Reimbursement Requested	From _____	To _____	$ _____
Prescription Reimbursement Requested	From _____	To _____	$ _____
Vision Reimbursement Requested	From _____	To _____	$ _____
Dental Reimbursement Requested	From _____	To _____	$ _____
Orthodontia Reimbursement Requested *(Ortho contract available on website.)*	From _____	To _____	$ _____

Total Reimbursement Requested: $ _____

Include independent, third-party documentation of your expenses with this claim form. If any of these expenses were covered by insurance, attach a copy of the explanation of benefits (EOB) from your insurance company. For expenses that are not eligible for submission to insurance, send a copy of a bill or invoice identifying the service, service date, and total charges. If required documentation is not attached, your reimbursement may be delayed.

I certify that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my qualified dependents, and/or spouse. These expenses have not previously been reimbursed under any plan and I will not seek reimbursement under any other health plan. I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed through my health FSA may not be claimed on my individual tax return.

Signature: _____ Date: _____

☐ Check here if your address has changed.

New address: _____

***Please inform your employer if your address has changed.*

2021

Health Flexible Spending Account (FSA) Reimbursement Request

Allegiance® a Cigna Company

Filing a Claim

Please read these important reminders for quick and efficient reimbursement:

- Please make sure to fill out your form completely (employer, ID#, your name). Documentation must include service dates, service description and charges for services received.
- Combine all like reimbursement requests. For example, If you are submitting several prescription receipts for reimbursement, enter the range of dates over which the purchases were made and the total of all the receipts on the prescription line:

  Prescription Reimbursement Request From: 7/1/17 To: 7/31/17 $145.78

- Service dates must be within the plan year to be eligible expenses. If your employment terminates during the plan year, service dates must be within the plan year **and** while you were an active participant in the plan (ie: eligible and making contributions).
- If the service is eligible for insurance, an explanation of benefits must accompany the claim form, unless the bill from the provider shows the amount that insurance has paid, or the receipt is clearly a co-pay amount. **Bills from providers that estimate insurance payment will not be reimbursed.**
- If the reimbursement requested is not eligible for submission to insurance for reimbursement consideration, a bill or receipt showing date, service and charges is adequate documentation of the expense, as long as there is no reference to insurance coverage on the bill or receipt.

Eligible claims received must total at least $5.00 before a check will be mailed. Electronic payments do not have a minimum reimbursement.

Save Time!

Direct deposit is a convenient and easy way to receive your flex reimbursement - see www.askallegiance.com and sign up today!

2806 S. Garfield St. P.O. Box 3018 | Missoula, MT 59806-3018 | Phone: 877.424.3570 | Fax: 877.424.3539 | www.askallegiance.com