FSA and HRA Reimbursement Form

This form is not for Peak One Debit Card Claims.

Instructions

You may also submit claims by logging in to your Peak One Portal at www.PeakOneAdmin.com or using your Peak One Mobile App. This form is for reimbursement of any out of pocket expenses where your Peak One Debit Card was not used. If your Peak One Debit Card was used, please log in to your online account or mobile app to upload a receipt or submit a copy of your receipt with your receipt reminder.

Step 1

- Complete the required fields (*)
- If changes need to be made to your profile (name, address, etc.), please contact your HR Department or log in to your online portal to update your contact information
- Missing information may delay the processing of your reimbursement request

Step 2

- You may submit one claim form for all claims included in this reimbursement request
- Date of Service: Provide the date the expenses were incurred, including the year
- Claimant: Provide the name of the patient
- Description of Service: Include a brief description of the service and/or drug name
- Amount of Service: Provide the total amount you are requesting for reimbursement. This is the amount equal to or less than the amount owed to your service provider.

Step 3

- Sign and submit the completed claim form with supporting claim documentation
  Fax: 844-560-6756
  Email: MemberCare@PeakOneAdmin.com

Questions? Call our MemberCare Department at 866-315-1777

Documentation Requirements

Verification of expenses, required by the IRS, includes a valid receipt and/or a copy of the Explanation of Benefits (EOB) containing the following information:

- Provider Name – Facility or person who provided the service, or if a purchase, where item was purchased (i.e. hospital, doctor, pharmacy)
- Date of Service – Date services occurred or date item was purchased
- Name – Person who received the service or whom the item is for
- Type of Service – Detailed description of the service provided or item purchased
- Patient Responsibility – The amount charged for services that the patient is responsible for paying. This is the amount due after insurance.

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Section 1

Employee Full Name*:		Employer Name*:	
Mailing Address	City	State	Zip
Email Address		Phone Number:	

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and accurate. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my eligible dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. I understand Peak One Administration, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the information provided, I understand I am responsible for notifying Peak One Administration. 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.

Employee Signature Verification X_____ **Date** _____

Required to process reimbursement

Section 2

Date of Service	Claimant	Description of Service	Amount of Service
			$
			$
			$
			$
			$
			$
			$
		Total Amount Requested for Reimbursement	$