Reimbursement Request Form with Individual Coverage HRA (ICHRA)

Employer Name: ______________________________

Participant Name (First, MI, Last): ______________________________

Social Security Number: ______________________________

Address: ______________________________

City, ST, ZIP: ______________________________

Date of Birth:________/________/________ Phone Number: (______) ______________

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claimant Name	Date of Service	Amount	*Code	Type of Service/Item Purchased	# of Miles	Claim Ref #
John Sample	*10/1/2021*	*$ 150*	*F*	*Doctor visit copay*	*12*	*Example*
		$				01
		$				02
		$				03
		$				04
		$				05
		$				06

Use one of the Code's below to indicate the type of claim this is. Certain restrictions may apply and not all Codes may be eligible for reimbursement under your Plan. Refer to your Summary Plan Description (SPD) for a description of eligible benefits. If your employer offers multiple benefit types, Lifetime Benefit Solutions will process the reimbursement based on the rules established by your employer.

*Plan Code	Plan Code Description
F	Flexible Spending Account (FSA) or Limited Purpose FSA: Health Care Expenses Only. For Dependent Care expenses, use the Dependent Care Account Reimbursement Request Form
IC	Individual Coverage Health Reimbursement Account (ICHRA)
P	Parking Account (cannot claim miles associated with Parking)
T	Transit Account (cannot claim miles associated with Transit)
M	To submit for medical mileage associated with Debit Card transactions. You will only be reimbursed for the medical mileage associated with the miles traveled, since you paid for the service with the Debit Card.

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I understand that the individual coverage HRA will reimburse me for a medical care expense incurred during a month only if I have (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during that month. Similarly, I understand that the individual coverage HRA will reimburse me for a medical care expense my family member incurred during a month only if my family member has (or had) individual health insurance coverage, Medicare Part A and B, or Medicare Part C during that month. By signing below, I am attesting that I (or my family member) meet this requirement.

Please note that you must complete both page 1 and 2 of the claim form if you are requesting reimbursement from an Individual Coverage Health Reimbursement Account (ICHRA).

For reimbursement from an Individual Coverage Health Reimbursement Account you must sign and date this form below. Your family member does not need to sign or date the form. Please mail OR fax the completed form (but not both) with any required documentation within the claim timeline defined in your Summary Plan Description (SPD) to:

Lifetime Benefit Solutions Claims Dept.
PO Box 211126
Eagan, MN 55121
Fax # (877) 256-7228

A. I, ______________________________, am requesting reimbursement for a medical care expense incurred during the month of __________________, and for that month I am (or was) covered under the following health coverage:____.

Instructions: Complete the following if you're requesting reimbursement of a family member's medical care expense from the individual coverage HRA.

B. I, _________________________, am requesting reimbursement for a medical care expense incurred by ____, during the month of ________________, and for that month this family member is (or was) covered under the following health coverage: ____. I hereby affirm that the above information is true and accurate.

Instructions: If you are requesting reimbursement for a medical care expense incurred by you and a family member, you must complete both A and B above.

I hereby affirm that the above information is true and accurate.

Signed: ____

Date: ____

Reimbursement Request Instructions

- For faster reimbursement processing you may be able to submit your claims online at www.lifetimebenefitsolutions.com.
- Complete the top section, including Social Security Number or Employee ID.
- Submit one expense (either a product or service) per row, even if items are contained on the same receipt.
- Label the receipts to correspond to the Claim Ref #.
- If you have more items than the form can accept, use additional forms.
- Do not "lump" or group items together or write.
- The expenses you submit must qualify as valid expenses under the terms of the Plan, and the claimant receiving the services must be a qualifying individual as defined in the Plan.
- Retain a copy of the Reimbursement Request Form and receipts for your own personal records
- For each medical claim covered by your insurance carrier, submit an Explanation of Benefits (EOB). If your claims are not submitted to your insurance carrier, provide an itemized bill showing: date of service, provider name, patient name, charged amount, and description of services rendered.
- Do not send credit card receipts, original receipts or cancelled checks.
- If you are submitting a request for reimbursement for insurance policy premiums, the bill from the insurance carrier must identify the participant, premium amount, coverage period and policy number.
- Call Lifetime Benefit Solutions Customer Service with questions at (800) 327-7130 during standard week-day business hours.
- Mail OR fax (but not both!) completed form with required documentation to:Lifetime Benefit Solutions Claims Dept.
  PO Box 211126
  Eagan, MN 55121
  Fax # (877) 256-7228

Reporting Medical Mileage

- Medical mileage rates are set by the IRS and can be applied to transportation primarily for and essential to medical care.
- Indicate the total number of miles incurred with each service provided (i.e. round-trip miles to visit the doctor).
- Lifetime Benefit Solutions will apply the current mileage rate and include the mileage amount in your total reimbursement.
- You may be required to produce additional documentation for each mileage expense you claim.

Dependent Care Claims

- Please use the separate form titled Dependent Care Account Reimbursement Request Form.

Parking/Transit Claims

- The only type of parking that is eligible for tax-free reimbursement is qualified parking on (or near) the employer's facility, or on (or near) a location from which the employee commutes to work by public transportation. If the parking is on (or near) the employee's residence, it is not eligible for tax-free reimbursement.