Benefit Bank reimbursement form

Did you forget to use your Benefit Bank card when paying for a covered service?

What does my Benefit Bank card cover?
Use your Benefit Bank card to pay for dental services, fitness memberships and/or eyewear.

When do I use this form?
Complete the form on the back of this flyer and return it to us if you have paid for a service(s) covered by your Benefit Bank, but did not use your Benefit Bank card to pay for that service(s). The reimbursement will be deducted from your Benefit Bank balance.*

How do I get my reimbursement?
• Complete the form on the back of this flyer
• Submit dated original receipts or copies of bank/credit statements showing the charge for covered services before March 31, 2021.

We accept multiple receipts and requests on one form, so you can be reimbursed all at once!

1-800-325-5669 (TRS 711)
8 a.m.–8 p.m., Monday–Friday
(Oct. 1–March 31, seven days a week.)
fallonhealth.org/medicare

*You must have funds available in your Benefit Bank to be eligible for reimbursement. Reimbursement amounts may vary depending on the amount remaining on your card.
Benefit Bank Reimbursement Form

Use this form to request a reimbursement for services covered by your Benefit Bank. Reimbursement amounts may vary depending on the amount remaining on your card.

Member information

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<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
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<th>Address</th>
<th>City</th>
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<th>ZIP</th>
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<thead>
<tr>
<th>Member’s ID #</th>
<th>Telephone number</th>
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Service for reimbursement

<table>
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<tr>
<th>Type of service</th>
<th>Location</th>
<th>Benefit year</th>
<th>Amount requested</th>
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Information needed for reimbursement

- This completed form. (Must be received before March 31 of the following year for expenses incurred by December 31.)
- Dated original receipts or copies of bank/credit statements showing the charge for covered services. These should reflect the dollar amount you are requesting. If you paid by check, please send a copy of the front and back of the cancelled check.

Certification and authorization (This form must be signed and dated below by the member.)

Reimbursement is subject to approval by Fallon Health. Please allow 4-6 weeks from receipt for reimbursement.

Agreement:
I certify that the information above is correct to the best of my knowledge. I am claiming reimbursement only for eligible expenses incurred during the applicable benefit year and for eligible members.

Member’s signature ____________________________________________________________

Date ____________________________

Two ways to get reimbursed:
1. Mail completed form to:
   Fallon Health
   P.O. Box 211308
   Eagan, MN 55121-2908

2. Email completed form to:
   reimbursements@fallonhealth.org

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