YourWay FSA | ONEBRIDGE for your benefit

Health FSA Reimbursement Form

FS01

Skip the form!

Log into your account at **portal.yourwaybenefits.com** to submit your supporting documentation online.
To submit your paper form, follow instructions provided below and send to: **OneBridge FSA, PO Box 80866, Seattle, WA 98108.**

1 Participant Information (Please fill out your benefit information below.)

Participant Number or SSN: _____ Date of Birth: _____

Name: _____

Address: _____ Is this a new address?: ☐

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Direct Deposit Information

Bank Name: _____ Account Type: ☐ Checking ☐ Savings

Routing Number: _____ Account Number: _____

2 Reimbursement Request

- Itemize your expenses in the table provided below. Please list one expense per line and attach copies of your supporting documentation.
- Proper supporting documentation must contain the following 5 items:
  - Covered individual (patient) name
  - Date the expense was incurred
  - Service provider name
  - Description of service
  - Out-of-pocket amount to be reimbursed
- Send photocopies of your form and documentation, keep the originals for your records.
- Explanation of Benefits (EOBs) from your insurance carrier are recommended supporting documentation.
- Ensure documentation is legible. Please do not use a highlighter.
- Cancelled checks, balance forward statements, and credit card receipts do not contain all of the required information and are NOT acceptable.
- Certain types of expenses may require a Letter of Medical Necessity. For these expenses, please complete the Letter of Medical Necessity Form or attach a copy of a letter from your doctor.

Reimbursement Details

Covered Individual	Date of Service	Description of Service	Reimbursement Amount
☐ Self ☐ Spouse ☐ Dependent Name: _____ SSN: _____ DOB: _____			

Authorization (signature required to process claims)

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- The expenses listed above qualify for reimbursement under applicable IRS regulations and guidance in the event a letter of medical necessity is required for a product or service, I have provided one as applicable.
- I am requesting reimbursement for my own personal experiences or those of my eligible dependents.
- These services have already been incurred.
- I have not and will not seek reimbursement for this expense from any other plan or party, and such expenses are not reimbursable from another source.
- I understand OneBridge Benefits reserves the right to deny a claim if I have not provided supporting documentation or if there is reason to believe the expense is not qualified as defined under Summary Plan Description or regulatory guidance. In such instance, I may be responsible for reimbursing the plan for such expense.

Participant Signature: _____ Date: _____