Card transaction Substantiation form

BENEFITHelp Solutions

To help us process your benefits card transaction quickly, please print clearly and return this form as instructed. Please complete all sections of the form. If the form is incomplete or additional information is required, your transaction approval may be delayed. Please do not use a fax cover sheet.

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Mailing address	* City	* State	* ZIP
* Contact number	* Email address		☐ New address
* Employer			* Group identification (if known)

Section 2 Card transaction(s)

1	* Name of dependent or self	* Transaction date (MM/DD/YY)	* Out-of-pocket cost
	* Name of provider or merchant	* Type of service or product description	
2	* Name of dependent or self	* Transaction date (MM/DD/YY)	* Out-of-pocket cost
	* Name of provider or merchant	* Type of service or product description	
3	* Name of dependent or self	* Transaction date (MM/DD/YY)	* Out-of-pocket cost
	* Name of provider or merchant	* Type of service or product description	

The Benefits MasterCard will automatically verify prescription drugs and group-specific medical plan copayments (not coinsurance or deductibles), but the card is not yet capable of identifying all eligible medical purchases. For expenses not automatically verified, the law requires additional substantiation for approval. Please attach the necessary documentation. Documentation must include: (a) the patient receiving care; (b) a description of the service or product; (c) who delivered the product or service; (d) the date of service (this is often different from the paid or billed date); and (e) your final out-of-pocket responsibility. A credit card receipt will not satisfy all documentation requirements.

* Total on this form

Section 3 Authorization (please sign below)

I acknowledge and certify that:

- The information submitted with this request is accurate and complete to the best of my knowledge.
- The transactions were for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan.
- I will not seek reimbursement for this expense from another plan or party.
- I understand the use of my Benefits MasterCard for services or goods incurred in a previous year is not permissible, and I will need to offset or refund my account to resolve an ineligible transaction.
- I understand BenefitHelp Solutions reserves the right to deny all or part of a card transaction if I have not provided substantiation, or if there is reason to believe the expense is not qualified as defined in my Summary Plan Document.

* Employee signature	* Signature date
X	

Ready to submit? Mail, fax or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland, OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com
Questions? Contact BenefitHelp Solutions at 888-398-8057.