Reimbursement Request Form

Completion Guide

This form is for the reimbursement of any out-of-pocket expenses. Documentation to substantiate purchases made with your debit card must be submitted with a copy of a Receipt Reminder. Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Step 1: Consumer Information

- Complete required fields with consumer information and follow the steps below.

Step 2: Reimbursement Information

- **Plan Type**: Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Did You File Online**: If a claim was filed online at https://firstambankparticipant.lh1ondemand.com, mark "Y" for yes; if not, mark "N" for no.
- **Date(s) Expense(s) Incurred**: Provide the date or range of dates the expenses were incurred.
- **Merchant/Provider Name**: Provide the name of the merchant or facility where the expense was incurred.
- **Name of Person Receiving Product/Service**: Provide your name or the name of the tax dependent for which the service was provided or product purchased for.
- **Claim Amount**: Provide the total amount requested for the specified expense.
- **Total Reimbursement Requested**: Total the amounts in the "Claim Amount" boxes.

Step 2b: Dependent Care Provider Signature and Certification

- Should the daycare provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Step 3: Consumer Certification

- Sign and date the form after reading the Consumer Certification.

Documentation Requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (Please be advised: if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider
- For Adult Care Services, a letter from the doctor or a Medical Necessity Form is required to identify that the dependent is physically or mentally disabled and unable to self-care.

(Please be advised: If a receipt is unavailable or unable to confirm day care provider, additional provider verification will need to be provided which includes either a provider signature or tax identification number.)

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

Instructions:

1. Complete all sections of this form.
2. Securely email, mail or fax completed form and **documentation** to:
   Secure Email: FirstAmBank@service.healthaccountservices.com
   Address: PO BOX 2843, Fargo, ND 58108-2843
   Fax: (833) 950-1240
3. If you have any questions about completing this form, please contact First American Bank Health Account Services at (866) 449-1150. We have representatives available Monday-Friday, 7:00 am to 7:00 pm CT.

Step 1: Consumer Information
*Required Fields

*Consumer Name (First, MI, Last)

*Employer Name

/ /
*Birth Date (MM/DD/YYYY)

- -
*Social Security Number

( ) -
*Phone Number

*Permanent Address

Email Address

*City

*State

*Zip Code

Step 2: Reimbursement Information

Step 2a: Claim Information

*Plan Type[1]	*Did You File Online (Y or N)	*Date(s) Expense(s) Incurred	*Merchant/Provider Name	*Name of Person Receiving Product/Service	*Claim Amount
					$
					$
					$
[1]Plan Types				*Total Reimbursement Requested	=

FSA-Flexible Spending Account; DCA-Dependent Care Account; LFSA-Limited Flexible Spending Account; HRA-Health Reimbursement Arrangement

Step 2b: Dependent Care Provider Signature and Certification (Dependent Care Claims Only)
If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your daycare provider must complete this step. If you would prefer to file only one claim for the plan year, please access the Recurring Dependent Care Request Form at https://firstambankparticipant.lh1ondemand.com

*Dependent's Name	* Dependent's Date of Birth (mm/dd/yyyy)	*Dependent's Social Security Number	*Service Type (Choose One)
			☐ Child Care ☐ Adult Care

*If choosing Adult Care as an expense, please submit a Medical Necessity Form if you haven't already.

I certify the information provided above is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the consumer to provide receipts for reimbursement purposes.

*Dependent Care Provider Signature

Step 3: Consumer Certification
I certify that the reimbursement request I am submitting contains eligible expenses as defined by the IRS and I have not been previously reimbursed for these expenses, nor am I seeking reimbursement for these expenses from any other source. I understand that First American Bank Health Account Services, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. I certify that the reimbursement is for the purpose of a qualified expenditure for an eligible individual as defined by the Internal Revenue Service (IRS) Code. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify First American Bank Health Account Services. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. I acknowledge that this form may be electronically signed via a digitized version of my written signature or with a digital certification using my full name. I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Consumer Signature

*Date