This form is for verification of the BASIC FLEX CARD transactions only.

No reimbursements will be made from this form.

INSTRUCTIONS FOR MEDICAL AND DEPENDENT CARE REIMBURSEMENT VERIFICATION

- The card may only be used for eligible expenses incurred during the plan year.
- **You must keep your eligible Flex Plan purchases separate from other purchases that you make at the same point of sale.**
- You must submit documentation for all expenses paid with the BASIC FLEX CARD within 30 days of services except office visits & Rx co-pays. You will receive a reminder notice 15 days from the date of service if we have not received verification.
- Complete the information on the verification form for each amount swiped.
- **If documentation is not received within 30 days your card will be inactivated and your employer will take a payroll deduction for the ineligible amount.**
- Submit your verification form and documentation to BASIC, 9246 Portage Industrial Dr., Portage MI 49024, or fax to 269-327-0716 or 800-391-6562.

MEDICAL REIMBURSEMENT ACCOUNT

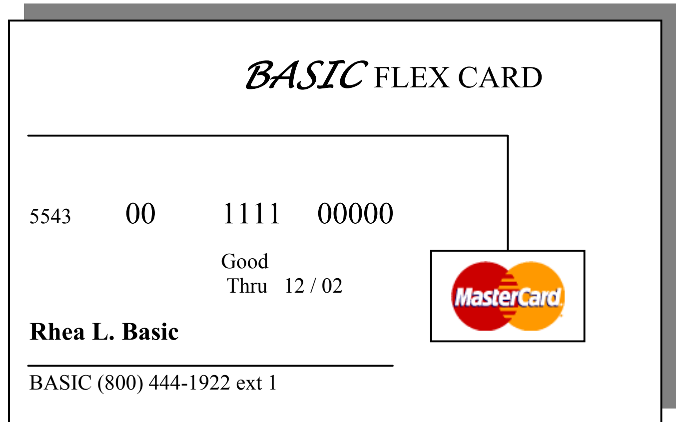
- Only expenses for your qualified dependents are eligible (i.e. spouse & children).
- Documentation must be invoices or other written statements from the third parties that provided the services.
- **The documentation must show the providers name and address, the dates the services were provided, the amounts charged for the services, and a brief description of the services.**
- **Do not use this card for services your insurance carrier has not yet processed.**
- In general, the types of expenses for medical services that can be reimbursed by the Plan are the same types of expenses that the Internal Revenue Service would allow for the health expense deduction under Internal Revenue Code Section 213. Further information can be found by obtaining IRS Publication 502 by calling 1-800-829-3676.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

- You may have your provider sign the claim form in the appropriate place or attach a separate receipt from your provider.
- You must show the name, address, and tax identification number of the provider, the dates the services were provided and the amounts charged for the services.
- In general, the types of expenses for dependent care services which can be reimbursed by the Card are the same type of expenses which the Internal Revenue Service would consider for the dependent care tax credit as employment-related expenses under Internal Revenue Service Code Section 21(b)(2). Further information can be found by obtaining IRS Publication 503 by calling 1-800-829-3676.

(Revised 05/02)

* **If you receive reimbursement for expenses, you may not claim these expenses for income tax purposes.**



BASIC FLEX CARD

Verification Form

This form is for
BASIC FLEX CARD receipt verification only.

Instructions on back side

NO REIMBURSEMENTS MADE FROM THIS FORM

Company: **Van Buren County**

Name: ______________________________ Social Security Number: ____________________

Phone: ____________________ email: ____

MEDICAL EXPENSES & DEPENDENT/CHILD CARE EXPENSES

Date	Provider	Amount
________	______________________________	____________
________	______________________________	____________
________	______________________________	____________
________	______________________________	____________
	TOTAL	$___________

*****DO NOT SEND IN CREDIT CARD RECEIPTS AS DOCUMENTATION, THEY WILL NOT BE ACCEPTED. WE MUST HAVE A STATEMENT FROM THE PROVIDER SHOWING THE DATE OF SERVICE, DESCRIPTION OF SERVICE PROVIDED AND CHARGE AMOUNT*****

If any of the above is for dependent/child care expenses please provide the following information:

Name of Dependent Care Provider: ________________________ Provider's Taxpayer ID #________________

Address of Provider: ____

Signature of Care Provider: ______________________________________ Date: ________________

I certify that if the expenses paid above do not meet the requirements set forth by the IRS, I will be required to refund the plan back for any ineligible payments made. I also understand that if the required refund is not made within the time allowed my employer will withhold the amount from my next paycheck.

I also understand that B.A.S.I.C. has the right and can deactivate my card. If the card is deactivated, I will need to pay the expense and submit all claims in hard copy and wait for the processing BEFORE I receive payment.

Reviewed By: ______________ Date:____________ Approved: $_____________ Denied: $______________

Reason for denial: ____