Chard Snyder Benefit Card Substantiation Form

Do not use this form to request a reimbursement. Complete and submit this form ONLY if you have received an email/letter from Chard Snyder requesting further information.

Submit your documentation on your Chard Snyder online account or on the Chard Snyder Mobile App for quickest processing and reimbursement. Paper forms can be submitted by fax or mail, but expect longer processing times for these methods.

Company Information (PLEASE PRINT)	
Company Name	Division (if applicable)

Participant Information (PLEASE PRINT)			
Last Name		Primary Phone	
First Name		Secondary Phone	
SSN (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)	Email Address	
Street Address			
City		State	ZIP

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Dependent Name	**Relationship**	**Date of Birth**

Healthcare Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) Card Substantiations Only

Please indicate your qualifying expenses below. ***DO NOT include expenses reimbursed by any other source.***

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From	through	**TOTAL Healthcare Card Amount**
Description (Please list a brief description below of services – e.g., Prescription, co-pay, contact solution, etc…)			**$** _____ **(REQUIRED)**
IMPORTANT: If this is a Limited Healthcare Spending Account - ONLY submit claims for dental and/or vision expenses.			

CLAIM CERTIFICATION

I certify these expenses for which reimbursement is requested on my Flexible Spending Account or health Reimbursement Account have been incurred by me, my spouse or my eligible dependent(s) and are not payable by any other benefit plan/program. I will not claim credit for these expenses on my individual income tax return.

Signature	Date

SEND THIS FORM AND A COPY OF RECEIPTS TO CHARD SNYDER (DO NOT SEND ORGINAL RECEIPTS)

Please submit this form with your documentation to Chard Snyder by one of the two methods listed to the right

☑ **Fax to:** Local (513) 459-9947 / Toll-Free (888) 245-8452 ***(Please DO NOT include a fax cover page)***

☑ **Mail to:** PO Box 2924, Fargo, ND 58108-2924

Flexible Spending Account
Chard Snyder Benefit Card Substantiation Instructions

1. **Complete all company and employee information** on the front page (please print/type). Include your e-mail address if you want to receive an automatic e-mail notification whenever a claim is processed and when a reimbursement is approved for you to receive payment.
2. **Attach supporting documentation.** A copy of a receipt or EOB must accompany this request for each claim submitted for reimbursement. Each claim request must include the following information to be eligible for reimbursement:
   - ☑ Original date of service (not the date you paid the provider)
   - ☑ Description of the service performed (refer to list of eligible expenses to identify valid services)
   - ☑ Provider's name and address (If submitting receipts for dependent daycare expenses)
   - ☑ Amount charged to you (do not include amounts reimbursed or paid by another source)
3. **Healthcare Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) Chard Snyder Benefit Card Substantiations Only:** Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expense as required
4. **You must sign and date** the *Claim Certification* section on the front of this page.
5. **Fax or Mail** this form and supporting documentation directly to Chard Snyder:
   - ☑ **Fax:** Local 513.459.9947 / Toll-Free 888.245.8452 **(*Please DO NOT include a Fax Cover Page*)**
   - ☑ **Mail:** PO Box 2924, Fargo, ND 58108-2924
6. **If you have questions** please contact us:
   - ☑ **Call Customer Service:** 513.459.9997 | 800.982.7715
   - ☑ **Visit our Website:** www.chard-snyder.com
7. **Important reminders:**

   To ensure your claim is processed as soon as possible, and avoid delays:
   - ☑ Include the email or letter you received asking for further information about your claim
   - ☑ Do NOT use a fax cover page when faxing
   - ☑ Do NOT highlight any part of your receipts, bills, etc.
   - ☑ Only mail copies of receipts, bills, etc. (Keep your originals)
   - ☑ Multiple receipts should be totaled on one claim form
   - ☑ Payments are issued after receipt and processing, subject to claim approval
   - ☑ Claims may not be paid across accounts (healthcare from dependent daycare and vice versa)
   - ☑ Any items for which you are reimbursed cannot be claimed again as deductions or credits on your individual tax return at the end of the tax year
   - ☑ You may only be reimbursed for eligible expenses from the current plan year
   - ☑ Orthodontia expenses are reimbursed as designated by the provider
   - ☑ Payment will be made directly to you. Payments cannot be made to a provider or another person
   - ☑ Cancelled checks are NOT acceptable as proof of payment
   - ☑ Limited Healthcare Flexible Spending Accounts may only reimburse claims for dental and/or vision expenses

Sign up for Direct Deposit on your online account or on the mobile app for quicker reimbursement than receiving a check.