



Benny® Card Receipt Submittal Form

To: Benefit Administration Company, LLC
Attention: Flex Claims Processing/ Benny® Card
Fax: (206) 682-8016
Email: FlexCS@baclink.com
Phone: (206) 625-1800 or (800) 967-3709

Company Name: _____
 Participant Name: _____
 Date: _____
 Number of Pages: _____
 Email Address: _____
 Daytime Phone Number: _____

- | |
|---|
| Acceptable documentation is: |
| <ol style="list-style-type: none"> 1) Explanation of Benefits (EOB) from the insurance company; 2) Statement or bill from the health care provider that shows date of service, services provided, patient name, and your financial responsibility; 3) Cash register receipt for over-the-counter purchases (i.e., contact lens supplies, etc.) |

Description of Expense:

Date Expense Incurred	Name & Relationship of Person Incurring Expense	Description of Service/Expense	Name of Service Provider	Your Expense
				\$

Fax legible copies of your receipts with this cover sheet. Keep original receipts for your records.

**Please submit this form with all faxed or mailed Benny® Card receipts.
Do not use this form when submitting manual claims.**

CERTIFICATION BY THE PLAN PARTICIPANT

I certify that I am responsible for the validity of these receipts and that the expenses listed are not eligible for further reimbursement under any other health plan. I further certify that I have not and will not claim the listed expenses as an income tax deduction.

Signature of Participant _____ Date _____