

# QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT CLAIM FORM



## QSEHRA GUIDELINES

*It sure is easy.*

This document will help you submit a claim for reimbursement from your QSEHRA account.

### Did You Pay Out-of-Pocket for an Eligible Expense?

Use the form on page 2 to submit a claim to get paid back using money from your account. There are two ways to submit a claim:

#### 1. FAX

Submit claim to 316-272-4841;  
Attn: Surency Flex Claims.

#### 2. US MAIL

Surency Flex, P.O. Box 789773,  
Wichita, KS 67278-9773

### Want to Get Paid Back Automatically?

Sign up for Direct Deposit and after you submit a claim, Surency will automatically deposit those dollars back into your bank account. There are two ways to set up Direct Deposit:

#### 1. MEMBER ACCOUNT AT SURENCY.COM

Log into your Member Account at Surency.com  
to input bank information.

#### 2. PAPER DIRECT DEPOSIT FORM

Visit Surency.com to download a Direct Deposit form.  
Complete and return to Surency.

### For Future Purchases Use Your Surency Flex Benefits Card to Pay for Expenses

Your **Surency Flex Benefits Card** is a special-purpose Visa® Card that gives you an easy, automatic way to pay for eligible expenses. The Benefits Card lets you electronically access the pre-tax amounts set aside in your Surency Flex accounts. Use it when paying for eligible expenses at a provider or merchant that accepts Visa Cards and uses an inventory control system. These transactions may be automatically substantiated, meaning you don't have to file a claim and may not have to submit a receipt. However, always keep all documentation for tax purposes or in case Surency requests further documentation.

#### **How to Use Your Card:**

1. Have the cashier ring up all of your items together.
2. When it's time to pay, swipe your Surency Flex Benefits Card first. Select 'credit' and sign for your purchase. Optional: In addition to your signature, for added security you can set up a PIN number to access your funds by calling 866-898-9795. If you have a PIN number, select 'debit' and enter your PIN.
3. All eligible expenses will be paid for from your account and deducted from your total.
4. If you are purchasing non-eligible items, you will need to have a second form of payment available for those items.
5. Keep your receipts in the event that further validation is needed.



866-818-8805 | Surency.com



# QUALIFIED SMALL EMPLOYER HRA CLAIM FORM

\_\_\_\_\_  
Last Name, First Name, MI (Please Print)

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Social Security or Employee ID

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, ZIP

Check if NEW ADDRESS

## QSEHRA

Date Medical Care Provided	Merchant/Provider Name	General Medical Expense/Item Description	Name of Person Receiving Service/Product	Medical Mileage	Claim Amount (Amount of your responsibility)
<b>TOTAL</b>					

**Attach copies of Explanation of Benefit (EOB) statement(s) or provider receipts if there is no insurance. Copies must include the date(s) of service.** Please do not send originals of your EOB's or your insurance statements - keep originals for your records. A signed Letter of Medical Necessity from your provider may also be required if the expense is considered "dual purpose." Dual purpose is defined as those items that have both a medical purpose and a personal/cosmetic or general health purpose.

**Missing information may delay the processing of your reimbursement.**

## Reimbursement Guidelines

- The reimbursement request expense must be an IRS eligible expense and incurred during the Plan Year. (Claims for future dates of service are not eligible for reimbursement.)
- The reimbursement request must not have been previously reimbursed nor are you seeking reimbursement from insurance or any other source.
- Attach a copy of your insurance company's Explanation of Benefits (indicating date of service), or copies of receipts/bills if there is no insurance coverage to document the amounts.

4. The medical mileage indicated must be for transportation primarily for and essential to medical care and associated with the dates of service identified above. The standard medical mileage rate is set by the IRS annually and will be calculated by Surency when determined eligible expenses for unreimbursed medical expenses.

**\* Generally, reimbursement requests will not be considered for reimbursement later than 90 days from the end of your company's Plan Year. For specific guidance, please contact Surency at 866-818-8805.**

## IRS Documentation Requirements:

Each item claimed must be supported with proper documentation, otherwise your claim will not be processed. The following should be included with each piece of documentation submitted to Surency with your completed claim form:

- Name of Provider
- Type of Service/Expense
- Date of Service/Expense
- Dollar Amount of Service/Expense
- Prescription and Name of Drug (if applicable)
- Please Note: Credit card receipts or cancelled checks are not eligible documentation per the IRS and cannot be accepted

I certify that the information above is true to the best of my knowledge and that my spouse, dependents, and I are covered under a minimum essential coverage health plan as defined by the Affordable Care Act for all dates for which I am claiming expenses under my QSEHRA plan. I understand that failure to maintain minimum essential coverage for any month will make me subject to the Affordable Care Act's Individual Mandate Tax under 26 U.S.C. §5000A and will result in any reimbursements received from this QSEHRA to be taxable. I also certify that all reimbursement requests submitted are IRS eligible expenses and I have not been reimbursed for these expenses in the past nor am I seeking reimbursement for these expenses from any other source. I understand that Surency, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

**(Request cannot be accepted without participant's signature.)**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

**Return completed form back to Surency at fax: 316-272-4841  
or mail: P.O. Box 789773, Wichita, KS 67278-9773**

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