FSA | Flexible Spending Account
Healthcare Reimbursement

Gallagher | HealthInvest

Submit completed form online: (1) Log in at **goHealthInvest.com**; (2) Click the **envelope icon** (✉) to send as an attachment via secure messaging. Or, **mail to**: Gallagher HealthInvest FSA, PO Box 4390, Clinton, IA 52733-4390. **Questions?** Call **1-844-342-5505.**

FS01

1 Participant Information

Participant Number or SSN: _____ Date of Birth: _____

Name: _____

Address: _____ Check if new address ☐

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Direct Deposit Information

Bank Name: _____ Account type: ◯ Checking ◯ Savings

Routing Number: _____ Account Number: _____

2 Reimbursement Request

1. Itemize your expenses in the table provided below. Please list one expense per line and include supporting documentation. The Explanation of Benefits (EOB) from your insurance carrier or an itemized invoice from your provider usually has everything we need.
2. For most claims, supporting documentation must contain all of the following: patient name, date of service, service provider name, description of service, and out-of-pocket amount.
3. Certain types of expenses may require a Letter of Medical Necessity (LOMN) from your provider. Your provider can use our standard LOMN (available online after logging in and clicking Resources), or they can use their own.
4. Ensure documentation is legible. Please do not use a highlighter. Cancelled checks, balance forward statements, and credit card receipts do not contain all of the required information and are NOT acceptable.
5. You may submit photocopies of this form and documentation. Keep the originals for your records.

Reimbursement Details

Covered Individual	Date of Service	Description of Service	Reimbursement Amount
Self ◯ Spouse ◯ Dependent ◯ Name: _____ SSN: _____ DOB: _____			

3 Authorization (signature required to process reimbursement)

By signing and submitting this form, I acknowledge and certify that: (1) The information being submitted is accurate and complete; (2) The expenses listed above qualify for reimbursement under applicable IRS regulations and guidance to the best of my knowledge; (3) If a Letter of Medical Necessity is required for a product or service, I am providing or will provided one; (4) I am requesting reimbursement for my own personal expenses or those of my spouse or eligible dependents; (5) These services have already been provided and the out-of-pocket expenses have been incurred; (6) I have not and will not seek reimbursement for these expenses from any other plan or party, and such expenses are not reimbursable from another source; and (7) I understand Gallagher HealthInvest reserves the right to deny a claim or debit card transaction if I have not provided proper substantiation or if there is reason to believe the expense is not qualified as defined in the Summary Plan Description or regulatory guidance, in which case I may be responsible for reimbursing the Plan for such expense.

Participant Signature: _____ Date: _____