Benefit Bank reimbursement form

Did you forget to use your Benefit Bank card when paying for a covered service?

What does my Benefit Bank card cover?

Use your Benefit Bank card to pay for dental care, prescription eyewear, gym/fitness memberships, prescription hearing aids, approved online fitness classes and WW® online membership.

When do I use this form?

Complete the form on the back of this flyer and return it to us if you have paid for a service(s) covered by your Benefit Bank, but did not use your Benefit Bank card to pay for that service(s). The reimbursement will be deducted from your Benefit Bank balance.*

How do I get my reimbursement?

- Complete the form on the back of this flyer.
- Submit dated original receipts or copies of bank/credit card statements showing the charge for covered services before March 31 of the following year for expenses incurred January 1 through December 31.

We accept multiple receipts and requests on one form, so you can be reimbursed all at once!

1-800-325-5669 (TRS 711)
8 a.m.–8 p.m., Monday–Friday
(7 days a week, Oct.1–March 31).

fallonhealth.org/medicare

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**You must have funds available in your Benefit Bank to be eligible for reimbursement. Reimbursement amounts may vary depending on the amount remaining on your card.*

Benefit Bank Reimbursement Form

Use this form to request a reimbursement for services covered by your Benefit Bank. Reimbursement amounts may vary depending on the amount remaining on your card.

Two ways to get reimbursed:

1. **Mail completed form to:**
   Fallon Health
   P.O. Box 211308
   Eagan, MN 55121-2908
2. **Email completed form to:**
   reimbursements@fallonhealth.org

Member information

Last name | First name | Middle initial

Address | City | State ZIP

( )

Member's ID # | Telephone number

Service for reimbursement

Type of service	Provider/Location	Benefit year	Amount requested

Information needed for reimbursement

- ❑ This completed form. (Must be received before March 31 of the following year for expenses incurred January 1 through December 31.)
- ❑ Dated original receipts or copies of bank/credit card statements showing the charge for covered services. These should reflect the dollar amount you are requesting. If you paid by check, please send a copy of the front and back of the cancelled check.

Certification and authorization (This form must be signed and dated below by the member.)

Reimbursement is subject to approval by Fallon Health. Please allow 4-6 weeks from receipt for reimbursement.

Agreement:
I certify that the information above is correct to the best of my knowledge. I am claiming reimbursement only for eligible expenses incurred during the applicable benefit year and for eligible members.

Member's signature _____

Date _____

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