

# Align Smart-Choice Accounts Health Savings Account (HSA) Receipts and Documentation

See the below examples of different types of expenses and receipts that would need to be provided upon submitting your claim. Use this as a guide to ensure you are submitting the documentation that will be required for quick and easy payment.

## MEDICAL EXPENSES

**TIP:** An Explanation of Benefits (EOB) is the preferred documentation for validating medical claims.

### Valid Medical Receipt Sample

A valid receipt contains the following items:

1. Service provider
2. Service date
3. Service description
4. Amount you're responsible for

### Invalid Medical Receipt Sample

Common problems with receipts:

1. Includes a statement date, but not the service date
2. Includes an amount but no indication of how much you're responsible for
3. Doesn't include a description of service
4. Patient name isn't indicated
5. Doesn't include a specific service provider name

May 09, 2026

**HEALTH CARE SERVICES, INC.**

1 Provider: M. THOMAS      2 Service date: 04/15/2026

Type of Service	Amount Billed	(-) Plan Discounts	(-) Your Plan Paid
OFFICE VISITS	118.00	50.39	17.61
CLAIM	118.00	50.39	17.61

4 YOUR ITEMIZED RESPONSIBILITY TO PROVIDER\*\*

(-) Deductible	(=) Copay	(+) Coinsurance	Non Covered	Amount You Owe
CLAIM 0.00	0.00	0.00	0.00	50.00
CLAIM TOTAL	0.00	0.00	0.00	50.00

\*\*This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

**General Hospital**  
100 Main Street  
PO BOX 500  
Anytown, MA 12345-4321


RETURN SERVICE REQUESTED

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
1 2/1/2026	2 \$573.34	3 12340000

SHOW AMOUNT PAID HERE \$

JOE BROWN  
500 SCHOOL STREET  
ANYTOWN, MA 12345-4321

4 MAKE CHECKS PAYABLE / REMIT TO: **GENERAL HOSPITAL**  
100 MAIN STREET  
PO BOX 500  
ANYTOWN, MA 1235-4321



## DENTAL RECEIPTS

**TIP:** An Explanation of Benefits (EOB) is the preferred documentation for validating dental claims.

### Valid Dental Receipt Sample

A valid receipt contains the following items:

1. Service provider
2. Date of service
3. Description of service
4. Amount you're responsible for

### Orthodontia Services

Refer to the Receipt of Orthodontic Treatment Form, found on the benefits website under Forms and Documents, for what's required.

You may be reimbursed:

- Monthly
- After each installment
- In a onetime payment

If you're paying in installments, submit a claim and your receipt or payment coupon each time.

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Signa Dental  
Signa Health and Life Insurance Company

Your explanation of dental benefits  
(For claim processed on Nov. 10, 2026) **THIS IS NOT A BILL**

1 HEALTH CARE PROFESSIONAL NAME: TOWN DENTAL GROUP, LTD. 2 Service date: Apr. 7, 2026

AMOUNT CHARGED	CONTRACTED AMOUNT	AMOUNT ELIGIBLE FOR COVERAGE	AMOUNT ELIGIBLE FOR COVERAGE	REMAINING BALANCE	YOUR PLAN COVERED
		60.00	21.00	21.00	21.00
		70.00	32.00	32.00	32.00
		50.00	16.00	0.00	0.00
		180.00	69.00	53.00	53.00
				Amount paid by your plan	53.00
				Customer's responsibility	16.00

3

4

## Invalid Dental Receipt Sample

Common problems with receipts:

1. Balance forward amount
2. Multiple service descriptions
3. Insurance payment not itemized
4. Multiple plan years
5. Ineligible expense
6. Total amount doesn't reflect what you're responsible for

SINGLE FAMILY LEDGER				
John Q. Dentist, D.D.S.				
Date: 05/29/26			Page: 1	
Guar Name: Sam Sample			Chart No: 12345	
123 Any Street Anytown, CA 00000-0000			Billing Type: 2	
DATE	DESCRIPTION	PATIENT	CHARGE	BALANCE
09/30/26	Balance Forward	Ann	148.00	148.00
10/01/26	Deliver Invisalign	Ann	0.00	148.00
10/01/26	Full Mouth Xrays	Chris	101.00	249.00
10/16/26	Periodic oral evaluation	Chris	35.00	284.00
10/16/26	Periodontal maintenance	Chris	96.00	380.00
11/02/26	Crown-porcelain/ceramic substr.	Molly	955.00	1335.00
11/04/26	Dental Ins Payment	Lane	-212.80	1122.20
11/28/26	Composite, 2 surf posterior	Lane	168.00	1,290.20
12/15/26	Dental Ins Payment	Chris	-448.96	841.24
12/21/26	Check Payment - Thank You	-	-100.00	713.20
04/15/26	Opalescence 20%, 10%, 15%	Chris	100.00	713.20
05/24/26	Strmt Statement		0.00	713.20
<b>TOTAL FAMILY BALANCE AS OF 05/17/2026:</b>				<b>713.20</b>
YTD Finance Charges			0.00	
YTD Late Charges			0.00	
YTD Family Payments			350.00	
YTD Insurance Payments			224.00	

## VISION RECEIPTS

### Valid Receipt Sample

A valid receipt contains the following items:

1. Service description
2. Amount you're responsible for
3. Date of service
4. Service provider

### EyesWideOpen, Inc.

Jim Smith, OD  
www.eyeswideopeninc.com

### STATEMENT

DESCRIPTION	AM7	PENDING INSURANCE	ADJ	PATIENT FALANCE
New Comp. Exam	135.00	29.00	80.00	30.00
Refraction	25.00	13.50	111.50	15.20
Deluxe Frame	145.00	130.00	3.80	15.20
Progressive VSP	539.00	389.00	200.00	200.00
Antf-Reflective Coating	100.00	42.00	58.00	58.00
UV Lens	29.00	19.00	10.00	10.00
Patient Credn Card	-313.20	0.00	-	-313.20

PLEASE PAY THIS AMT 0.00

PENDING INSURANCE 28.50

ACCOUNT BALANCE 28.50

PROVIDER: J. SMITH

DATE OF SERVICE: 04/15/2026

INVOICE: 13458

### Invalid Vision Receipt Sample

Common problems with receipts:

1. Doesn't include a description of the product
2. Amount doesn't indicate how much you're responsible for after insurance or discounts
3. Includes the payment date but not the date the service occurred

### Vision Company

100 MAIN STREET  
ANYTOWN, CA 00000  
555-123-4567

Cashier: Krista

TRANSACTION 00-1234-56

TOTAL \$184.99

CREDIT CARD SALE \$184.99

VISA 4032

14-JAN-2026 4:20:14P

\$184.99 | Method: SWIPED

VISA XXXXXXXXXXXX4032

Auth #:0123450

SIGNATURE VERIFIED

## HEALTHCARE SUPPLIES RECEIPTS

**TIP:** Examples of eligible health care supplies include bandages, gauze, elastic wraps, braces, and supports. For online purchases, tax and shipping of eligible items are also eligible for reimbursement.

### Valid Healthcare Supplies Receipt

#### Sample

A valid receipt contains the following items:

1. Service provider
2. Date of purchase
3. Description of service or product
4. Amount of the product or service
5. Who the service or product is for

1- **shop.com**

2- ORDER PLACED: **MAY 15, 2026**  
SHOP.COM ORDER NUMBER: 115-349134-38  
ORDER TOTAL: \$17.42

**SHIPPED ON MAY 16, 2026**

3- ITEMS ORDERED: PRICE  
1 OPTI-FREE REPLENISH MULTI-PURPOSE  
DISINFECTING SOLUTION, 10 OZ, 2 CT \$15.98

4- ITEM(S) SUBTOTAL: \$15.98  
SHIPPING & HANDLING: \$0.00  
TOTAL BEFORE TAX: \$15.98  
SALES TAX: \$1.44  
TOTAL FOR THIS SHIPMENT: \$17.42

5- SHIPPING ADDRESS: **JUDY SMITH**  
345 MAIN ST  
W. BRANCH, CA 30495

### Invalid Healthcare Supplies Receipt

#### Sample

Common problems with receipts:

1. Doesn't include a description of the product
2. Amount doesn't indicate how much you're responsible for after insurance or discounts

*Corner Drug Store*  
100 MAIN STREET  
ANYTOWN, CA 00000  
555-123-4567

813 0609 0043 12/30/2016 7:06 PM

1- **TRANSACTION 00-1234-56**

2- **TOTAL 5.00**  
VISA ACCT 1234 5.00  
CHANGE .00

US DEBIT  
Integrated Chip Card

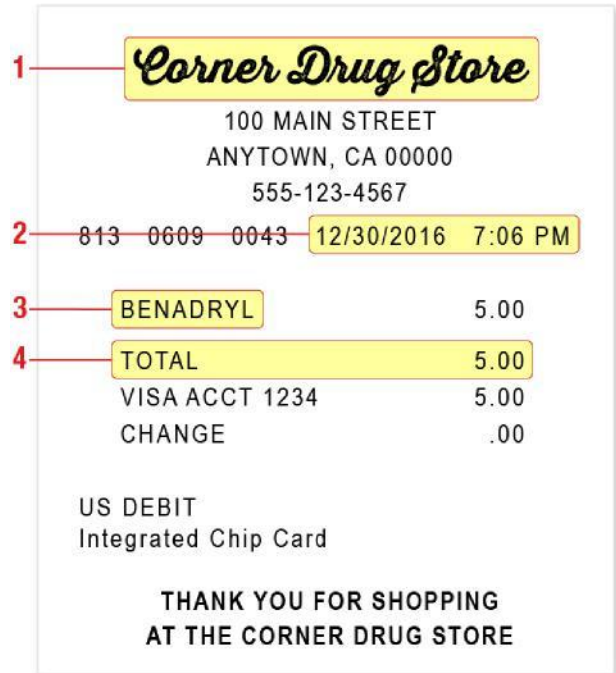
**THANK YOU FOR SHOPPING  
AT THE CORNER DRUG STORE**

## OVER-THE-COUNTER MEDICINE RECEIPTS

### Valid OTC Receipt Sample

A valid receipt contains the following items:

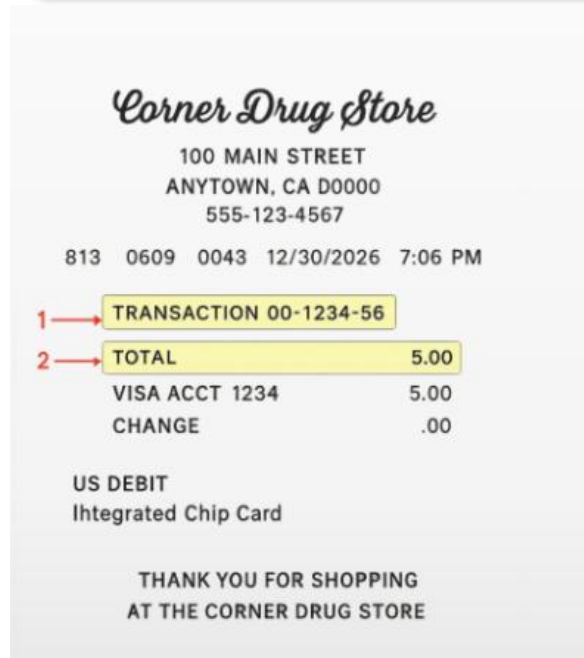
1. Retailer name
2. Date of purchase
3. Product description
4. Amount you're responsible for



### Invalid OTC Receipt Sample

Common problems with receipts:

1. Doesn't include a description of the product
2. Amount doesn't indicate how much you're responsible for after insurance or discounts



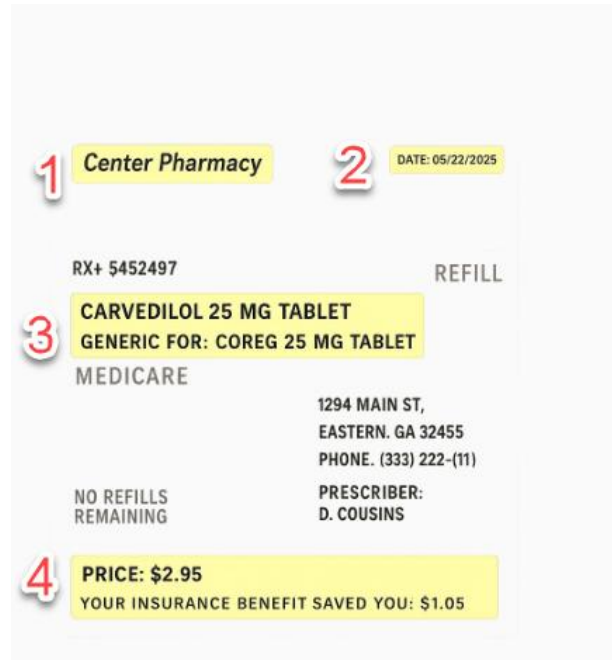
## PRESCRIPTION DRUG RECEIPTS

**TIP:** Provide the receipt that the pharmacist attached to the prescription rather than the cash register receipt.

### Valid Prescription Receipt Sample

A valid receipt contains the following items:

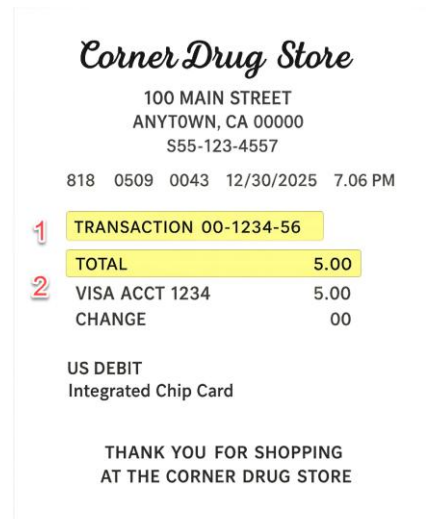
1. Service provider
2. Service date
3. Description of service or product
4. Amount you're responsible for



### Invalid Prescription Receipt Sample

Common problems with receipts:

1. Doesn't include a description of the product
2. Amount doesn't indicate how much you're responsible for after insurance or discounts



## HEALTHCARE PREMIUM RECEIPTS

**TIP:** Your documentation may look different from the sample below. However, the information highlighted is what your documentation needs to include.

### Valid Healthcare Premium Receipt Sample

A valid receipt contains the following items:

1. Insurance company name
3. Coverage period (start and end dates)
4. Premium description **and** premium type (i.e. medical, prescription drug, dental, vision)
5. Premium amount

Health premiums require **one** of the following:

- Payment coupon indicating the monthly amount
- Bank statement indicating the name of the insurance company and amount

- Pay or retirement stub indicating deductions for health premiums

Medicare premiums require **one** of the following:

- A Medicare statement indicating your monthly amount
- A Social Security Administration letter indicating the new Medicare rates and the effective date

### Invalid Healthcare Premium Receipt Sample:

Common problems with receipts:

1. Doesn't include a description of the product
2. Amount doesn't indicate how much you're responsible for after insurance or discounts

Unlike other documents that must accompany each claim, you typically only need to provide the type of premium once a year. With your first claim each year, or if there is a change during the year, you need to request or submit additional documentation that shows which type of premium you're paying—whether medical, prescription drug, dental, vision, etc.

**1** Healthcare Provider of Texas  
11 Main Street, Anytown, TX 00000  
1-800-555-1234

SMITH, MARY  
1 SCHOOL STREET  
ANYTOWN, TX 00000

ID Number: 1234567  
**2** Coverage From: 01/01/2026  
Coverage Through: 01/31/2026  
Date Billed: 12/14/2025  
Payment Due By: 01/15/2026

NOTICE OF PREMIUM DUE

To ensure continuous coverage, please pay your premium before the due date.

Health Insurance Coverage – Standard Plan F **3**  
Mary Smith

**4** CURRENT PERIOD TOTAL: \$147.00  
TOTAL AMOUNT DUE: \$147.00

**America Bank**  
CONVENIENCE CHECKING - 012345678

ACCOUNT HISTORY

Date	Description	Amount	Available Balance
03/17/2026	CHECK DEPOSIT	\$100.00	\$605.00
03/15/2026	WEB PAYMENT - CARLE	-\$50.00	\$555.00
03/14/2026	CHECKCARD PURCHASE	-\$60.00	\$495.00
03/12/2026	BANKING TRANSFER	\$25.00	\$520.00
<b>1</b> 03/10/2026	<b>2</b> ELECTRONIC WITHDRAWAL - HEALTH PLAN INC.	-\$150.00	\$370.00
03/06/2026	CHECKCARD PURCHASE	-\$50.00	\$485.00
03/05/2026	CHECK DEPOSIT	\$30.00	\$500.00

## **Expenses Incurred Outside of United States**

To submit a claim for services received or products purchased outside of the United States, provide:

- Receipts and other documentation in English
- Expenses in U.S. dollars

If receipts and documentation are in another language besides English:

- They must be translated. You, the service provider, or someone else can do the translation.
- The translation can appear on the receipts and documentation, or in a separate document.

If you're unable to convert the expenses to U.S. dollars from another currency, submit them. Your Smart-Choice Account will convert the amounts to dollars.