Alight Smart-Choice Accounts
Health Care Flexible Spending Account (HCFSA)
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
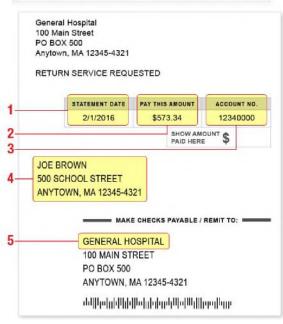A valid receipt contains the following items:

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

May 09, 2016

HEALTH CARE SERVICES, INC.

1 — Claim detail for: **JOHN SMITH**

2 — Provider: **M. THOMAS**   Service date: **04/15/2016**

3 —

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

YOUR ITEMIZED RESPONSIBILITY TO PROVIDER**

(=) Deductible	(+) Copay	(+) Coinsurance	(+) Non Covered	(=) Amount You Owe
5— 0.00	50.00	0.00	0.00	50.00
CLAIM TOTAL 0.00	50.00	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.

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

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

RETURN SERVICE REQUESTED

1 — STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
2/1/2016	$573.34	12340000

2 —
3 —   SHOW AMOUNT PAID HERE $

4 — JOE BROWN
500 SCHOOL STREET
ANYTOWN, MA 12345-4321

MAKE CHECKS PAYABLE / REMIT TO:

5 — GENERAL HOSPITAL
100 MAIN STREET
PO BOX 500
ANYTOWN, MA 12345-4321

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

Reminder: General oral hygiene products (toothpaste, toothbrush, floss) are not eligible for reimbursement even if purchased at a dental provider. Deduct the amount paid from the amount requested for reimbursement.

Valid Dental Receipt Sample
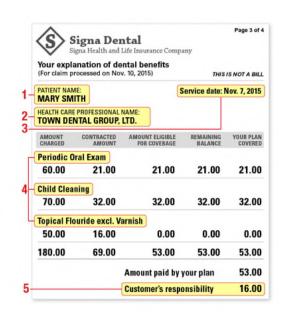A valid receipt contains the following items:

1. Patient name
2. Service provider
3. Date of service
4. Description of service
5. 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
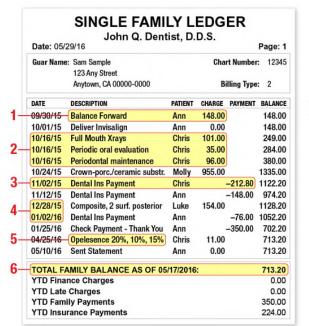- After each installment
- In a onetime payment

Page 3 of 4

Signa Dental
Signa Health and Life Insurance Company

Your explanation of dental benefits
(For claim processed on Nov. 10, 2015)

THIS IS NOT A BILL

1 — PATIENT NAME: MARY SMITH | Service date: Nov. 7, 2015
2 — HEALTH CARE PROFESSIONAL NAME: TOWN DENTAL GROUP, LTD.
3 —

	AMOUNT CHARGED	CONTRACTED AMOUNT	AMOUNT ELIGIBLE FOR COVERAGE	REMAINING BALANCE	YOUR PLAN COVERED
Periodic Oral Exam	60.00	21.00	21.00	21.00	21.00
Child Cleaning	70.00	32.00	32.00	32.00	32.00
Topical Flouride excl. Varnish	50.00	16.00	0.00	0.00	0.00
	180.00	69.00	53.00	53.00	53.00

Amount paid by your plan	53.00
Customer's responsibility	16.00

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

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: 05/29/16 — Page: 1

Guar Name: Sam Sample
123 Any Street
Anytown, CA 00000-0000

Chart Number: 12345

Billing Type: 2

DATE	DESCRIPTION	PATIENT	CHARGE	PAYMENT	BALANCE
09/30/15	Balance Forward	Ann	148.00		148.00
10/01/15	Deliver Invisalign	Ann	0.00		148.00
10/16/15	Full Mouth Xrays	Chris	101.00		249.00
10/16/15	Periodic oral evaluation	Chris	35.00		284.00
10/16/15	Periodontal maintenance	Chris	96.00		380.00
10/24/15	Crown-porc./ceramic substr.	Molly	955.00		1335.00
11/02/15	Dental Ins Payment	Chris		−212.80	1122.20
11/12/15	Dental Ins Payment	Ann		−148.00	974.20
12/28/15	Composite, 2 surf. posterior	Luke	154.00		1128.20
01/02/16	Dental Ins Payment	Ann		−76.00	1052.20
01/25/16	Check Payment - Thank You	Ann		−350.00	702.20
04/25/16	Opelesence 20%, 10%, 15%	Chris	11.00		713.20
05/10/16	Sent Statement	Ann	0.00		713.20

TOTAL FAMILY BALANCE AS OF 05/17/2016:	713.20
YTD Finance Charges	0.00
YTD Late Charges	0.00
YTD Family Payments	350.00
YTD Insurance Payments	224.00

1 — 09/30/15 Balance Forward
2 — 10/16/15 service descriptions
3 — 11/02/15 Dental Ins Payment
4 — 12/28/15 / 01/02/16
5 — 04/25/16 Opelesence 20%, 10%, 15%
6 — TOTAL FAMILY BALANCE

Valid Receipt Sample
A valid receipt contains the following items:

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

Tips and Reminders:

- Warranty or protection plans are not eligible. Deduct the amount paid from the amount requested for reimbursement.
- Surgeries on the eye are most often considered medical expense(s). Please select medical as the expense type.

EyesWideOpen, Inc.

Jim Smith, OD
www.eyeswideopeninc.com

STATEMENT

DESCRIPTION	AMT	PENDING INSURANCE	ADJ	PATIENT BALANCE
New Comp. Exam	135.00	25.00	80.00	30.00
Refraction	25.00	13.50	11.50	
Deluxe Frame	149.00	130.00	3.80	15.20
Progressive VSP	599.00	399.00		200.00
Anti-Reflective Coating	100.00	42.00		58.00
UV Lens	29.00	19.00		10.00
Patient Credit Card	–313.20			–313.20

PLEASE PAY THIS AMT	0.00
PENDING INSURANCE	28.50
ACCOUNT BALANCE	28.50

PATIENT: **JANE SIMPSON** PROVIDER: **J. SMITH**

DATE OF SERVICE: **04/15/2016**

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-2017 4:20:14P
$184.99 | Method: SWIPED
VISA XXXXXXXXXX4032
Auth #:0123450
SIGNATURE VERIFIED

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

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

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 include the specific amount for the itemized product being purchased

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. Patient
3. Service date
4. Description of service or product
5. Amount you're responsible for

Center Pharmacy | DATE: 05/22/2016

1 — Center Pharmacy
2 — JOHN H. JOHNSON
3 —

RX# 6452497   REFILL

4 — **CARVEDILOL 25 MG TABLET**
GENERIC FOR: COREG 25 MG TABLET

MEDICARE

1234 MAIN ST.
EASTERN, GA 32455
PHONE: (333) 222-1111

NO REFILLS
REMAINING

PRESCRIBER:
D. COUSINS

5 — **PRICE: $2.95**
YOUR INSURANCE BENEFIT SAVED YOU: **$1.05**

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

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

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.