VitaFlex
Excellence in Pre-Tax Benefits

Flexible Spending Accounts
One Page Claims Guide

Claims Eligibility

Only certain health and dependent care claims are eligible for reimbursement. The IRS establishes the guidelines for claim eligibility. This is normally considered to be medically necessary care to treat a diagnosed medical condition. Your eligible expenses must be incurred during the Plan Year and after your participation effective date. If you terminate employment, health expenses must be incurred prior to your termination date.

Documentation for Claims

You may be asked to submit documentation for your claims. The following information must be explicitly stated on the documents:

- Provider name
- Patient or child's name
- Date(s) of care or service
- Total amount charged
- Insurance payment(s)
- Description of service

Most Common Reasons for Denial

There are many reasons your claim may be denied or you may be asked for additional documentation. The most common reasons are:

- **Insurance estimate** - this is most common with dental claims as the dentist will not know for sure what your insurance is paying on the date of your appointment. To resolve this wait until you can obtain the **Explanation of Benefits** from your dental insurance.
- **Date of service unclear** - some statements or receipts will not show dates with the itemized list, this can cause issues as it will seem like the date the statement was printed and not be proof that the services happened that day. Getting an **updated statement** that line items the dates can resolve this if an **Explanation of Benefits** is not available.
- **Balance forward** - indicates that at least part of the charges listed do not include a description, usually supplying a copy of an **earlier statement** explaining the balance forward amount can resolve these.
- **Prepayment for services** - health services must have happened to be considered eligible. Dependent care services cannot be claimed more than one month in advance. **Resubmit at a later date** after the services have happened to address this.
- **Orthodontia** - if you're submitting a claim for braces or orthodontia, please be sure the **document states the payment is for orthodontia**. Orthodontia is the only type of claim where we use date of payment instead of date of service for determining the eligible plan year.

Filing Claims

Claims may be submitted as expenses are incurred, or they may be bundled and filed on a periodic basis. All claims for the 2019 Plan Year must be received by the claims submission deadline. Claim forms can be downloaded from our document library. Claims may be submitted using any of the following methods:

Online: www.vitaflex.net
Email: claims@vitamail.com
Fax: (866) 964-3539
US Mail: 900 N. Shoreline Blvd., Mountain View, CA 94043

What Is the BEST Document to Submit

- Dependent Care claims: **Complete VitaFlex Claim Form - Dependent Care FSA**, signed by the care provider and the participant.

Always include a completed VitaFlex Health FSA Claim Form with the below unless uploading claim through the website:

- Medical claim: **Explanation of Benefits** from insurance. Usually available 2-6 weeks after appointment.
- Dental claim: **Explanation of Benefits** from insurance. Usually available 2-8 weeks after appointment.
- Vision claim: **Itemized receipt**, usually a full page. Needs to indicate if lenses/contacts are prescription if the claim does not include the vision exam on the same receipt.
- Pharmacy Rx claims: **Itemized receipt** showing drug name, may need receipt with Rx number and scan of Rx box, bottle, or label showing the Rx number and the drug name.
- Pharmacy Over The Counter (OTC): **Itemized receipt** showing item name/description. May need OTC Prescription Form if it has an active ingredient or is considered a drug/medicine under the IRS guidelines.
- Non-traditional Medical Care: **Explanation of Benefits** from insurance. May need Statement of Medical Necessity Form if not normally an eligible expense or eligible only by referral, frequently need the diagnosis or Dx code to be shown for these types of service.

What Looks Right On A Document But Is Not Sufficient:

- Billing company if it is not the same as the provider name.
- Date of payment vs date of service or appointment.
- Subscriber/member/guarantor name vs the specific patient name.
- Amount you paid vs the total amount charged or billed, to prove your final responsibility to pay.
- Insurance estimate or implied discount vs itemized insurance payment to prove amount of total not owed by you.
- General type or category of service vs description of specific service and/or diagnosis and procedure codes. Descriptions of services should be specific when possible.
- Account statement from provider vs Explanation of Benefits from insurance. Statements will frequently not itemize the amount paid by your insurance.
- Predetermination of benefits vs Explanation of Benefits from insurance, a predetermination is issued before the services are rendered and do not represent final numbers or dollar amounts.

Additional Information

This FSA Plan Detail Sheet provides a brief summary of several important elements of your Pre-Tax Flexible Benefits Plan. Additional details may be found at www.vitaflex.net. For full Plan details, rules, and restrictions, please refer to the Summary Plan Description.