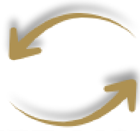

Claim Reimbursement Form

This form is used when you seek reimbursement for any eligible out-of-pocket expenses that have occurred. Your receipt(s) accompanying this form should include the following information: (1) Date of service, (2) Description of service or item purchased, (3) Dollar amount (patient responsibility only) and (4) Name of provider.

Participant Information

_______________________________ *Employee Full Name (Last, First, MI)*

_______________________________ *Employer Name*

(_______)__________-__________ *Phone Number*

__________-_______-_________ *Social Security Number*

Claim Codes

Plan Type Code		Service Code	
Code	Description	Code	Description
DCFSA	Dependent Care - Flexible Spending Account	MT	Mass Transit
FSA	Health - Flexible Spending Account	OT	Over the counter
HSA	Health Spending Account	PK	Parking
HRA	Health Reimbursement Arrangement	VS	Vision
ICHRA	Individual Coverage – Health Reimbursement Arrangement	MD	Medical
LPFSA	Limited Purpose - Flexible Spending Account	DN	Dental
TRNST	Transit	RX	Prescription Drugs
PKG	Parking	IP	Individual Premiums
		OTHR	Other

Claim Information

Online claim reimbursements are processed faster. To file a claim online, go to www.babdllc.com > hover over **Login** > Select **Employee** > Select **CDH** > Enter your credentials > Click **File a Claim** and follow the steps as indicated. For questions, contact your account manager at (469)688-8300.

Dependent Enrollment(s)

Plan Type Code	Date of Service (mm-dd-yyyy)	Service Code	Service Provider	Reimbursement Amount
				$
				$
				$
				$
				$

Reimbursement Method:
☐ Direct Deposit* ☐ Check

Reimburse to:
☐ Self* ☐ Physician: ______________________________

Physician Address: ______________________________
____

Plan Year: ____________

Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that BABD, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Dependent Care Account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify BABD. By submitting this form, I certify the above. Pursuant to the terms of the plan, benefit payments that are not timely claimed may be forfeited back to the plan. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

______________________________ *Employee Signature*

__________________ *Date*

Mail or Fax to:

Benefit Administration by Design LLC (BABD) | 5250 Hwy 78, Ste 750-223 | Sachse, TX 75048
Office: (469)688-8300 | Fax: (855)282-2333
Email: customerservice@babdllc.com