The Difference Card

REIMBURSEMENT FORM

###3T00230###################

NUMBER OF PAGES FAXED:

TO BE COMPLETED BY EMPLOYEE (Please Complete All Sections for Prompt Processing)

COMPANY NAME:

EMPLOYEE NAME (First, Middle, Last):

EMPLOYEE SOCIAL SECURITY (Last 4 digits only):

E-MAIL ADDRESS:

STEP 1: Complete this section of the reimbursement form for eligible expenses incurred during your plan year while you were a participant. Health Care expenses must be processed by your insurance company first. The insurance company or medical group will provide you with an EOB or appropriate documentation. An expense is incurred when the service is provided, not when you are billed or pay for the service.

Reimbursement Reminders
1. You must complete the boxes in this section for each expense in order for your claim to be processed properly.
2. Your receipts must contain the following:
- Date of Service
- Provider of Service
- Name of Patient
- Type of Service
- Amount of Service
3. An Explanation of Benefits or appropriate documentation from your insurance company or medical group and an itemized bill (receipt) is required to process this claim.
4. Copies of receipts for each expense claimed must be attached to the form.

Date of Service	Provider	Name of Patient	Type of Service	Amount of Service
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			TOTAL HEALTH CARE EXPENSE:	$

DID YOU ATTACH AN EOB OR APPROPRIATE DOCUMENTATION? ☐ YES ☐ NO

HAVE YOU PAID THE PROVIDER ALREADY FOR THE CLAIM(S) BEING SUBMITTED WITH THIS FORM? ☐ YES ☐ NO

IF APPLICABLE, WOULD YOU LIKE ANY REMAINING BALANCE APPLIED TOWARDS YOUR FSA ACCOUNT? ☐ YES ☐ NO

NOTES OR COMMENTS:

STEP 2: EMPLOYEE SIGNATURE REQUIRED (or adult dependent)

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Difference Card. I also hereby authorize the Difference Card to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Difference Card plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable. Upon termination, I agree to return "The Difference Card" within 1 business day. I acknowledge that any reimbursement requests will be processed within 4 - 12 business days and will not appear on the Difference Card website until processing is complete.

EMPLOYEE SIGNATURE

DATE (MM/DD/YYYY):

Complete and mail** to: The Difference Card, 245 Main Street, Suite 605, White Plains, NY 10601
Or Fax to 602-333-4252

*** If mailing claims, please do not staple or tape receipts to this form.*

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