ALERAPAY
POWERED BY ALERAEDGE

Reimbursement Request Form | EMAIL: AleraEdgePay@AleraGroup.com

For use with Health Care and Dependent Care Reimbursement Accounts

EMAIL TO: AleraEdgePay@AleraGroup.com

FAX TO: 585-641-7500
NO COVER PAGE REQUIRED PAGE 1 OF _____

Your Name (Last, First, MI)	Your Employer Name
Email Address *(if preferred)*	**Last 4-digits SS #**

Address	City	State	Zip Code

AUTHORIZATION—*My submission of this form is certification of the following:*

I have received and read all printed material describing this program and all administrative materials defining the operation of this Plan.
I am responsible for compliance with all applicable administrative processes, tax regulation and documentation.
The expenses submitted for reimbursement were rendered to me or an eligible member of my family during the period I was a participant in the Plan.
The expenses are not eligible for payment through my employer or from any other source, such as my spouse's employer's health plan.
I am submitting claims in accordance with IRS regulations and that expenses reimbursed under the Plan, may not be claimed as expenses for tax purposes; therefore, it is my responsibility for any tax reporting or other requirements with respect to reimbursed expenses.
If applicable, all medical expenses were incurred for medical care.
I understand that I should retain a copy of this form and all original receipts for my records.
The information contained herein is true and accurate to the best of my knowledge and that knowingly and intentionally giving false information or concealing information may be considered a criminal fraudulent insurance act.
ALERAPAY/*powered by ALERA EDGE*, is not required to retain copies of receipts beyond the current Plan year.

Employee Signature: _____ **Date:** _____

Health Care Reimbursement Requests *(If applicable, funds from more than one reimbursement Plan are drawn according to the Plan documents.)*

Submit correct documentation to assure rapid claim processing!
List each charge on a separate line (i.e. do not use one line for the total of several procedures or one patient).

Date of Service	Type of Service (Office Visit, Crown, Eyeglasses, Rx, etc.)	Patient Name	Relationship	Provider Name	★Amount Requested	Internal Use Only
					$	
					$	
					$	
					$	
					$	
				Total	$	

★Amount Requested must be filled or request will be denied.

Dependent/Child Care Reimbursement Requests

Reimbursement is only paid for services provided prior to the date your claim is submitted (i.e. claims for future dates of service cannot be paid).
Reimbursement requires an itemized statement from your providers be submitted with this form or use the certifications* with your providers signature below.

★—**Reimbursement is only available up to the balance to date in your account.**

Dates of Service MM/DD/YY thru MM/DD/YY No Future Dates	Dependent Name / Relationship	①Name/Address of Care Provider or Care Facility ②SS# or Tax ID / Type of Dependent Care Service (Daycare, Day Camp, Preschool, After School Care, etc.)		Amount Requested
		①		$
		②		
		①		$
		②		
		①		$
		②		
			Total	$

* Day Care Provider or Care Facility Certification:	* Day Care Provider or Care Facility Certification:
I certify that I provided dependent care services as detailed above.	**I certify that I provided dependent care services as detailed above.**
Print Name:	Print Name:
Original Signature:	Original Signature:
Date: SS#/Tax ID:	Date: SS#/Tax ID:

ALERAPay Internal Use Only ☐ ___/___/___ ☐ ___/___/___ ☐ ___/___/___ REV-7.2019