KAISER PERMANENTE®

Reimbursement Request Form

Completion Guide

This form is for the reimbursement of any out-of-pocket expenses. Documentation to substantiate purchases made with your Kaiser Permanente Health Payment card must be submitted with a copy of a Receipt Reminder or a Receipt and Substantiation Form. Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Step 1: Accountholder Information

- **E-mail address:** If you would prefer to receive notifications electronically or if your email address has changed, please update your information at https://kp.org/healthpayment. You may also call our Health Payment Services team at 1-877-761-3399 Monday through Friday (except holidays) 5:00 a.m.- 7:00 p.m. Pacific time.

Step 2a: Reimbursement Information

- **Plan Type**: Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Did You File Online**: If a claim was filed online at https://kp.org/healthpayment, mark "Y" for yes; if not, mark "N" for no.
- **Date(s) Expense(s) Incurred**: Provide the date or range of dates the expenses were incurred.
- **Merchant/Provider Name**: Provide the name of the merchant or facility where the expense was incurred.
- **Name of Person Receiving Product/Service**: Provide your name or the name of the tax dependent for which the service was provided or the product was purchased.
- **Claim Amount**: Provide the total amount requested for the specified expense.
- **Total Reimbursement Requested**: Total the amounts in the "Claim Amount" boxes.

Step 2b: Dependent Care Provider Signature and Certification

- Should the daycare provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Step 3: Participant Certification

- Sign and date the form after reading the Participant Certification.

Submit the completed form with the supporting documentation to Kaiser Permanente Health Payment Services:

Kaiser Permanente Health Payment Services, P.O. Box 1540, Fargo, ND 58107-1540
Fax: (877) 535-0821
Questions? Please call Health Payment Services at 1-**877-761-3399** (M-F, 5 a.m.-7 p.m. PT).

Documentation Requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (Please be advised: if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider
- For Adult Care Services, a letter from the doctor or a Medical Necessity Form is required to identify that the dependent is physically or mentally disabled and unable to self-care.

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

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Step 1: Accountholder Information

*Required Fields

*Accountholder Name (First, MI, Last)

*Employer Name

/ /

*Birth Date (MM/DD/YYYY)

*Social Security Number

( ) -

*Day Telephone

*Permanent Address

Email Address

*City

*State

*Zip Code

Step 2: Reimbursement Information

Step 2a: Claim Information

*Plan Type [1]	*Did You File Online (Y or N)	*Date(s) Expense(s) Incurred	*Merchant/Provider Name	*Name of Person Receiving Product/Service	*Claim Amount
					$
					$
					$
					$
				*Total Reimbursement Requested	=

[1]Plan Types

FSA-Flexible Spending Account; DCA-Dependent Care Account; LFSA-Limited Flexible Spending Account; HRA-Health Reimbursement Arrangement

Step 2b: Dependent Care Provider Signature and Certification (Dependent Care Claims Only)

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your daycare provider must complete Step 2a. If you would prefer to file only one claim for the plan year, please access the Recurring Dependent Care Request Form at https://kp.org/healthpayment.

*Dependent's Name	*Date of Birth (mm/dd/yyyy)	*Service Type (Choose One)
		☐ Child Care ☐ Adult Care

I certify the information provided above is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

*Dependent Care Provider Signature

Step 3: Participant Certification

I certify that the reimbursement 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 for these expenses from any other source. I understand that Kaiser Permanente, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify Kaiser Permanente Health Payment Services. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

*Accountholder Signature

*Date