Substitute Claim Form

FOR BENIVERSAL® FOLLOW-UP

YOU COULD BE GETTING YOUR REIMBURSEMENT FASTER! File your claim online via the employee portal (BRIWEB)or via the BRIMOBILE app, if allowed by your plan.

Employee Name

Member ID *(set by your employer. Typically an employee ID or SSN.)*

Employer

Check here if address has changed and provide new information below. ☐

Street or PO Box

City | State | ZIP

What are you requesting a reimbursement for? *(One claim type per form.)*

☐ Health Accounts (FSA, HRA) ☐ Dependent Care (Child care expenses) ☐ Commuter Expenses ☐ Other / Specialty Accounts

Provider & Type of Service *(i.e. RX, Co-pay, Dental, Child care, Parking)*	Start and End Dates *(MM/DD/YYYY)*	Person Receiving Service *(First and Last Name)*	Amount	Office Use
			$.	
			$.	
			$.	
			$.	
			$.	

CERTIFICATION AND AUTHORIZATION: By submitting the claim form, I certify that: (1) The information on this form is accurate and complete. (2) I am requesting reimbursement for eligible Medical expenses listed above. (3) I have itemized bills, receipts or EOBs verifying these expenses. (4) Each expense listed is for a service/item provided to me, my spouse or an eligible dependent, has not been purchased with a Beniversal® Prepaid Mastercard®, and will not seek reimbursement from any other plan or third-party. (5) Use of this service indicates my acceptance of the terms and conditions associated with my plan and available through my secure login at BenefitResource.com.

What you need to know when submitting your claim:

- Provide an itemized receipt or an EOB if required by your plan. Credit card receipts are generally not accepted.
- Check your plan highlights to determine:
  - What expenses are eligible
  - Required documentation for claim submissions
  - When claims must be submitted by

SUBMIT CLAIM BY MAIL:

Benefit Resource, LLC
PO BOX 642
Willow Grove, PA 19090

Please visit BenefitResource.com/ClaimsHelp for further assistance in filling out this form.