POLESTAR BENEFITS, INC. - REQUEST FOR REIMBURSEMENT

MEMBER INFORMATION

Company Name	
Employee Name	
Employee Phone #	
Employee Email	

Comments

SEND CLAIMS TO

Fax	(888) 539-9565
Email	claims@polestarbenefits.com
Mailing Address	412 Jefferson Parkway, Suite 202 Lake Oswego, OR 97035

Please visit www.polestarbenefits.com for additional forms and information.

REIMBURSEMENT REQUESTED

Please list eligible medical, dental, vision services and/or expenses for you and your family that you have not already claimed through Polestar Benefits, Inc. in the appropriate boxes below. Only list the amount of the expense you are eligible for and is not being reimbursed through another Plan, by another Administrator/Carrier.

Services for Reimbursement	Reimburse from FSA or DCA	Estimated Amount to Reimburse
	◉ FSA ○ DCA	$
	○ FSA ○ DCA	$
	○ FSA ○ DCA	$
	○ FSA ○ DCA	$
	○ FSA ○ DCA	$
	○ FSA ○ DCA	$
IF ANY EXPENSES WERE COVERED BY INSURANCE, PLEASE SEND THE EXPLANATION OF BENEFITS (EOB)	**EXPLANATION OF BENEFITS** **THIS IS NOT A BILL**	

4 Keys to a Quick Reimbursement

- Service Date
- Service Provided
- Cost of Service
- Provider / Member Name

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. ***IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED (see above), YOUR REIMBURSEMENT WILL BE DELAYED.***

I certify that these statements are true and that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my tax dependents, and/or spouse (if filing taxes jointly). I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed by Polestar Benefits, Inc. may not be claimed on my individual tax return at the end of the year.

Employee Signature **Date**

IF YOUR ADDRESS HAS CHANGED, PLEASE LIST BELOW.

Street/PO Box		
City	**State**	**Zip**

If you have questions about filing claims, please contact us!

Toll Free: (855) 222-3358

Email: claims@polestarbenefits.com