

Benefit Bank reimbursement form

Did you forget to use your Benefit Bank card
when paying for a covered service?



What does my Benefit Bank card cover?

Use your Benefit Bank card to pay for dental services, fitness memberships, hearing aids and/or eyewear.

When do I use this form?

Complete the form on the back of this flyer, and return it to us if you have paid for a service(s) covered by your Benefit Bank, but did not use your Benefit Bank card to pay for that service(s). The reimbursement will be deducted from your Benefit Bank balance.*

How do I get my reimbursement?

- Complete the form on the back of this flyer.
- Before March 31, 2022, submit dated original receipts or copies of bank/credit statements and payment showing the charge for covered services.

We accept multiple receipts and requests on one form, so you can be reimbursed all at once!

1-800-325-5669 (TRS 711)

8 a.m.–8 p.m., Monday–Friday
(Oct. 1–March 31, seven days a week.)

fallonhealth.org/medicare



* You must have funds available in your Benefit Bank to be eligible for reimbursement. Reimbursement amounts may vary depending on the amount remaining on your card.

Benefit Bank Reimbursement Form

Use this form to request a reimbursement for services covered by your Benefit Bank. Reimbursement amounts may vary depending on the amount remaining on your card.

Two ways to get reimbursed:

- 1. Mail completed form to:**
Fallon Health
P.O. Box 211308
Eagan, MN 55121-2908
- 2. Email completed form to:**
reimbursements@fallonhealth.org

Member information

Last name	First name	Middle initial
Address	City ()	State ZIP
Member's ID #	Telephone number	

Service for reimbursement

Type of service	Location	Benefit year	Amount requested

Information needed for reimbursement

- This completed form. (Must be received before March 31 of the following year for expenses incurred by December 31.)
- Dated original receipts or copies of bank/credit statements showing the charge for covered services. These should reflect the dollar amount you are requesting. If you paid by check, please send a copy of the front and back of the cancelled check.

Certification and authorization (This form must be signed and dated below by the member.)

Reimbursement is subject to approval by Fallon Health. Please allow 4-6 weeks from receipt for reimbursement.

Agreement:

I certify that the information above is correct to the best of my knowledge. I am claiming reimbursement only for eligible expenses incurred during the applicable benefit year and for eligible members.

Member's signature _____

Date _____

