DEBIT CARD DOCUMENTATION

If you received a request from ASIFlex to provide documentation of a card transaction, please complete this form in its entirety, provide legible documentation as instructed, and sign below. Please print clearly.

Your Name (Last, First, MI)	Your Employer Name		
Social Security No. or EID or PIN	**Daytime Telephone Number**		
Address	**City**	**State**	**Zip Code**

Documentation Required by IRS Guidelines - The IRS requires that **all** card transactions be substantiated. Although some transactions may be substantiated electronically, many require you to provide supporting documentation. Why? The card company reports only limited information to ASIFlex such as the card transaction date, merchant name and dollar amount. The IRS requires that you provide a **description of the service, the patient name, and the actual date the service was provided,** regardless when you paid. Not all services/supplies are qualified health care expenses (such as cosmetic treatments, teeth bleaching, non-prescription sunglasses, general health items, warranty contracts, etc.). The IRS requires you to provide documentation for **all dental, vision and hospital expenses; and for copayments that do not match your employer plan's flat-dollar copayment amount.** If the service/supply is determined to be ineligible, you must repay the ineligible amount to the plan. You can mail a check to ASI or contact finance@asiflex.com to arrange for the amount to be debited from your bank account. Alternatively, you can submit a manual paper claim to off-set the ineligible amount.

Complete the information below and provide documentation to substantiate the card transaction(s). Acceptable documentation includes:

- Your insurance payer Explanation of Benefits (EOB) statement
- Itemized statement from your health care provider that includes these five things:
  - Health care provider name/address
  - Patient Name
  - Date the service/supply was provided (not when you were billed, or when you paid)
  - Description of the health care service/supply
  - Dollar amount charged that matches the card transaction
- Pharmacy receipt, printout or mail-order statement
- Itemized cash register receipt for over-the-counter health care products

Note: Examples of unacceptable documentation include:

- cancelled checks
- credit card receipts
- balance forward/amount due/paid-on-account statements
- pre-treatment estimates
- statements for future dates of service, pretreatment estimates

Date(s) of Service	Name of Health Care Provider	Description of Service (X-ray, Lab, Crown, Eyeglasses, etc.)	Patient Name	Relationship to You	Card Transaction Amount	*ASIFlex Use Only*
					$	
					$	
					$	
					$	
				TOTAL	$ 0.00	

I certify that all expenses were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I understand that I am fully responsible for the accuracy of all information relating to this documentation, and that unless an expense is a qualified expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. This request will only be processed with this completed and signed Debit Card Documentation form and correct documentation. I understand the card may be temporarily inactivated until such time that complete and appropriate documentation is provided and/or until such time that I pay any owed amounts back to the Plan.

✔ Employee Signature _____ Date_____

FAX TO:
1-877-879-9038
PAGE # ____ OF ____
NO COVER PAGE REQUIRED

MAIL TO
ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

QUESTIONS:
WEBSITE: WWW.ASIFLEX.COM/DEBITCARD
MAIL: ASI@ASIFLEX.COM
PHONE: 800.659.3035