

POLESTAR BENEFITS, INC. - REQUEST FOR REIMBURSEMENT

MEMBER INFORMATION

SEND CLAIMS TO

Company Name		Comments	Fax	(888) 539-9565
Employee Name			Email	claims@polestarbenefits.com
Employee Phone #			Mailing Address	412 Jefferson Parkway, Suite 202
Employee Email				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 HRA, FSA, Transit or DCA	Estimated Amount to Reimburse
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> DCA	\$
	<input type="radio"/> HRA <input type="radio"/> FSA <input type="radio"/> TRN <input type="radio"/> 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

Please be sure to include:

- 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, 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

