Please attach the required documentation to your claim form and send to:
Stanley Benefits, Inc.
P. O. Box 8249
Greensboro, NC 27419

Fax Number 1-877-432-9247 Number of pages _____
OPTIONS FOR OBTAINING ACCOUNT INFORMATION
Website: www.stanleybenefits.com
Phone: 1-877-SBS-FLEX (1-877-727-3539); Email: flex@stanleybenefits.com

Flexible Spending Accounts
Claims Submission Guidelines

In an effort to consistently improve the service we provide our members, please comply with the following claims submission guidelines. A completed Flexible Spending Account Health Care and /or Dependent Care form is required for each claim submission, unless you are using your BENNY debit card for your transaction.

Health Care Claims - Cancelled checks, check copies, or bank statements are not sufficient documentation for claim reimbursement.

Medical or Dental Claims With Primary/Secondary Insurance Coverage	Medical or Dental Claims Without Primary/Secondary Insurance Coverage
Please include an Explanation of Benefits (EOB) to indicate the out-of-pocket expenses.	Please include an itemized bill or receipt from the provider that includes the following: • Patient's name • Type of service • Provider's name and address • Dollar amount • Date(s) of service
Prescription Drug Claims	**Vision Service Claims**
Please include an itemized bill or receipt from the provider that includes the following: • Patient's name • Prescription name and number • Provider's name and address • Dollar amount • Date(s) of service	Please include an itemized receipt for glasses and/or contact lenses that include the following: • Patient's name • Type of product • Provider's name and address • Dollar amount • Date(s) of service **Note:** Claims for enzyme cleaners and/or lens solutions must be accompanied with a receipt that identifies the type and brand name of the purchased product.
Medical Equipment Claims	**Therapy Claims**
Please include an itemized bill or receipt for the equipment and a physician's note that includes the following: • Patient's name • Type of equipment • Provider's name and address • Dollar amount • Date(s) of service	Please include an itemized receipt for therapy and a physician's note that includes the following: • Patient's name • Type of therapy (physical, massage, psycho, etc.) • Provider's name and address • Dollar amount • Date(s) of service **Note**: Therapy claims must also include a letter of medical necessity from the attending physician that prescribes the therapy as treatment for a specific medical condition.
Orthodontia Services *	**Maternity Services ***
Please send a copy of your orthodontia agreement (orthodontic contract) along with your completed claim form when treatment begins. The agreement must state: • Beginning date of service, approximate length of service, cost of service, record fee, down payment, monthly fees, insurance coverage (if any) • Monthly payment coupon or itemized receipt is sufficient documentation also	Please include a completed claim form indicating the paid/service date, year and dollar amount. Documentation must include an EOB and proof of payment that can include (***reimbursable when baby is delivered only for pre-paid services***): • Bill/receipt from the provider indicating payment(s) • Bill or statement of the childbirth or delivery

Dependent Care Claims - The following options may be used to submit a dependent care claim. Cancelled checks, check copies, or bank statements are not sufficient documentation for claim reimbursement.

Option One	Option Two
Provide a completed claim form that includes the signatures of both the daycare provider and the member.	Provide a completed claim form with third-party documentation containing: • Name and address of the provider • Provider's social security # / Tax ID # • Date(s) of service • Dollar amount

***Do not include or submit prepaid expenses or claims with future dates of service. IRS regulations require reimbursement of Health/Dependent Care expenses on an incurred service basis (when member receives service), not when formally paid or billed.**