

Please attach the required documentation to your claim form and send to:

Stanley Benefit Services
P. O. Box 29329
Greensboro, NC 27429-9329

Fax Number 1-877-432-9247 Number of pages _____
OPTIONS FOR OBTAINING ACCOUNT INFORMATION
Website www.stanleymail.com (pin # required)
Phone: 1-877-SBS-FLEX (1-877-727-3539)

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 SmartFlex debit card for your transaction.

Health Care Claims

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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Patient's name • Type of product • Provider's name and address • Dollar amount • Date(s) of service <p>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.</p>
Medical Equipment Claims	Therapy Claims
Please include an itemized bill or receipt for the equipment and a physician's note that includes the following: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Patient's name • Type of therapy (physical, massage, psycho, etc.) • Provider's name and address • Dollar amount • Date(s) of service <p>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.</p>
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: <ul style="list-style-type: none"> • 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 (<i>reimbursable when baby is delivered only for pre-paid services</i>): <ul style="list-style-type: none"> • Bill/receipt from the provider indicating payment(s) • Bill or statement of the childbirth or delivery

Dependent Care Claims

(The following options may be utilized to submit a dependent care claim.)

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: <ul style="list-style-type: none"> • 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.**