Pay-The-Provider Request Form
MEDICAL & DEPENDENT CARE

PTP

Please note: By completing this form, you are authorizing Crosby to pay your provider directly. You will need to submit this PTP request form with accompanying receipts or bills for each requested provider payment. Until your provider has been successfully established in Crosby's system, reimbursements will be mailed to your home address or transferred to your account via Direct Deposit as you have requested.

Employee Information

To update your address or email, please login to MyCrosbyBenefits.com

Please also notify employer of any address changes.

Employee Name ____ Eagle ID# ______________________
Last First MI

Employer: **Boston College** Email address: ____

Home Address: ____
Street City State Zip

Home Phone No. (______)__________________ Work Phone No. (______)________________________
area code area code ext.

Pay-The-Provider Expense Information

By completing this form, you are authorizing Crosby to pay your provider directly. Please complete a form for each provider for which payment is requested.

Description of Expense	Account Type (circle one)	Service Start	Service End	Amount*
____________________________	Med or DepCare	____/____/____	____/____/____	____________
____________________________	Med or DepCare	____/____/____	____/____/____	____________
____________________________	Med or DepCare	____/____/____	____/____/____	____________

TOTAL Pay-The-Provider Request $____________

Provider Information Section

Provider Name ____ Tax ID# ______________________

Mailing Address: ____
Street City State Zip

Provider Phone No. (______)__________________ Provider Email: _________________________________

Provider Signature

Provider may sign this section instead of submitting a bill/receipt.

To be completed by Provider: ***I certify that the services listed above have been provided.***

Provider Name: ____

Provider Signature: ____ Date: _________________________

*Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, Workers' Compensation, or any other policy of health insurance.

Include with this form all "Supporting Documentation" as defined in the Important Information section on the reverse side of this form. Retain a copy for your records. Canceled checks are not acceptable.

Employee Certification

By signing below, I hereby certify the following:

- I authorize payment directly to the Provider as indicated above.
- All expenses identified above are "Eligible Medical Expenses" or "Eligible Dependent Care Expenses" as defined in the SPD (Note: general information regarding eligible expense is provided on the reverse side).
- All expenses were incurred by me (the employee), my legal spouse, or an eligible dependent as defined in the SPD (Note: General information regarding eligible dependents is provided on the reverse side).
- I have not been reimbursed nor will I seek reimbursement of the expenses listed above from any other source (e.g. under a spouse's employer's plan).
- I will not deduct the above listed expenses on my personal federal and/or state income tax return for any year. My employer does not accept responsibility for direct payment to any individuals other than the employee.

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Please SIGN

Employee Signature ____ **Date** ___________________

IMPORTANT INFORMATION

Please note: Nothing in this section is intended to supersede or replace the provisions of the Summary Plan Description (SPD). If there is a conflict between this section of the Form and the SPD, the SPD controls.

Medical FSA

Eligible Medical Expenses - In general, only expenses for "medical care" as defined in your SPD are eligible for reimbursement under the Medical Care Reimbursement Account (as defined in Code Section 213(d) with notable exceptions). In all situations, only medical care expenses not reimbursed from any other source are reimbursable.

Medical and dental expenses covered partially by your health care plan(s) are generally allowable. Cosmetic procedures (for example, teeth bleaching) and drugs (prescription and nonprescription) to be used for a cosmetic purpose are not reimbursable. Orthodontia expenses can be reimbursed in one full sum or in monthly installments. Proper documentation of procedure and payment plan must accompany each claim form. For orthodontia expenses to be eligible, payment must have been made within the current plan year.

Legal Spouse and Eligible Dependents - Only Eligible Medical Expenses incurred by you, your "legal spouse" or "eligible dependents" (as defined in the SPD) are eligible for reimbursement. Generally, your legal spouse is your spouse as recognized by federal law. Your eligible dependents include any individual who would qualify as an eligible dependent as defined in Code Section 105.

Doctor's Notes - For some expenses, a medical practitioner note is required to verify that the expense qualifies as medical care. To be allowable, a medical practitioner note may be written by a doctor of medicine, dentistry, podiatry, optometry, an authorized chiropractor, an alternative healer or other qualified medical practitioner. A doctor's note must contain all of the following items: 1. date (a note must be provided each year); 2. patient's name; 3. doctor's name, address and signature; 4. the medical condition or statement of medical necessity; 5. the prescribed treatment; and 7. the duration of treatment required.

Dependent Care FSA

Dependent Care Eligible Expenses - The annual amount reimbursed cannot exceed the amount set forth in the SPD. The expenses must be "Eligible Employment Related Expenses" as defined in your SPD. Generally, eligible expenses are expenses that enable you (and your spouse, if applicable) to work or to look for work.

A "Qualifying Individual" is defined in more detail in your SPD. Generally, a Qualifying Individual is any one of the following:

- A "qualifying child" (as defined in Code Section 152(c)) who is under the age of 13 and who resides with you for more than half of the year;
- A dependent (as defined generally in Code Section 152) that is incapacitated and resides with you for more than half of the year*; or
- A legal spouse who is incapacitated and resides with you for more than half of the year.

Please consult with a qualified tax or legal advisor to determine if individuals for whom you are submitting reimbursement requests qualify.

Dependent Care expenses are not eligible if paid to a person who is claimed as a dependent by the employee. Every dollar that you are reimbursed tax free under this plan for Eligible Employment Related Expenses reduces the base amount for which you may be eligible for the Dependent Care Credit under Code Section 21. You are required to include the name, address, and TIN of the service provider on the Form 2441 that you must attach to your federal income tax return. Overnight camp is not an allowable expense**,** even on a prorated basis. Kindergarten is not an allowable expense.

Dependent care expenses submitted before the service is provided are not reimbursable. If a claim is submitted in advance of the actual service date, it may be denied. For example, expenses for a particular month should not be submitted until the last day of that month.

Both Medical and Dependent Care FSA

Fax (preferred), email or mail this form. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable.

Supporting Documentation - For All Expenses, attach bills or evidence of charges that clearly state all of the following:

1. Name of person receiving service (except for over-the-counter products)
2. Name and address of service provider
3. Nature of service or supplies (drug name if a prescription or over-the-counter medication)
4. Amount of reimbursable expense under the plan
5. Date(s) of service

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Please Note - Service dates for reimbursable expenses must fall within the plan year (or during the grace period if adopted by the employer). Expenses incurred before participation began or after participation has terminated will not be reimbursed. After enrollment, changes to a reimbursement account may only occur when there has been a qualified change in status. Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Contact your Human Resources Department or Crosby Benefit Systems for more information.