



Comprehensive Benefit Services, Inc. NEW Flexible Spending Plan Claim System Access

To: Flexible Spending Plan Participants

From: Danielle Harrington, Comprehensive Benefit Services, Inc.

To access your Flexible Spending Plan Account(s), please visit: www.myhrsites.com.

Choose: "My FSA" on the left side of the screen.

Please choose "Create Account." You will then be redirected to the following screen (Account Creation**):**

PLEASE COMPLETE THE YELLOW HIGHLIGHTED SECTIONS. KEEP IN MIND YOUR **EMPLOYEE ID** IS YOUR SOCIAL SECURITY #.

Account Creation

Create a new user account.

Enter the information below to create your account. Please contact your Administrator for questions regarding access to this site or for questions about balances and statements.

Name * * First * Last

Employee ID @ *no dashes

Employer ID * * CIPFIS

or

Card Number * *

New User ID * * must be between 8 and 18 characters

Password * * Password * * * Confirm Password
must be between 8 and 18 characters and include at least 1 capital letter and 1 number

Security Word * * *
(Mother's Maiden Name)

Birth City * * *

E-mail Address * *

** = required*

Once you are logged on, please choose Request Reimbursement under My Accounts on the left side of the screen and follow the instructions.

Request Reimbursement

Please click on “add new” to enter a new claim.

When you finish entering your claim(s), please read “Certification” section below.

New Claims

| Start Date | End Date | Amount | Claimant | Provider | Receipt |
|------------|----------|--------|----------|----------|---------|
|------------|----------|--------|----------|----------|---------|

Certification:

*By checking the box to the left, you certify the claim(s) you entered to be true and correct, to the best of your knowledge. Claim(s) *entered will not be reimbursed through any other medical/dependent care plans, including other medical/dependent care flex spending arrangements. I understand that I am responsible for providing proof to support each claim submitted for reimbursement.*

Please note: after submitting your claim(s) no edits are allowed.

When you click “add new,” you will see the following:

Add/Edit Claim

Service Dates (Enter the date(s) of service.)

Claim Amount (Enter the claim amt that will not be reimbursed through any other medical/dependent care plans, including other medical/dependent care flex spending arrangements.)

Provider (Enter the medical facility/physician or dependent care facility/provider name.)

Account Type (Select the correct account (and plan year): FSA=med flex spending; DC1= dep care flex spending.)

Receipt File (You may upload your receipt(s) that are scanned in your computer by using this feature.)

Notes (You may include any notes that correspond with this claim.)

Service Dates: ** Start Date* * End Date

Claim Amount *: \$ * * *

Claimant *: ▼

Provider: *



Account Type*:

select

| Type | Plan ID | Plan Dates | LastDayToSubmitClaims |
|------|---------|------------|-----------------------|
|------|---------|------------|-----------------------|

Receipt File: **NEW FEATURE!**

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Notes:

**

* = required

One new feature with this system is it gives you the capability of scanning in your claim receipts/statements and uploading them as you key in each claim. (This is just an option.)

Once you key in your last claim, you will have to certify your claims by checking the certification box, press submit and you will be taken to the following screen with submittal instructions.

Please read the following instructions:

You have successfully keyed in your claim(s).

If you have uploaded your receipt(s)/statement(s), please print your claim form and forward to the administrator for processing.

If you have *not* uploaded your receipt(s)/statement(s), please print your claim form and mail, scan/email or fax, along with receipt(s)/statement(s) to the administrator for processing.

Address:
 Comprehensive Benefit Services, Inc.
 799 Cambridge Street
 Cambridge, MA 02141
Email: dharrington@askcip.com / **Fax:** 617-354-1137

Signature & Date

Participant: Doe, John
 Tracking Number: 119
 Date Submitted: 1/24/2011
 Total Requested: \$60.00

Claims Submitted With Receipts:

| Start | End Date | Amount | Claimant | Provider |
|-------|----------|--------|----------|----------|
|-------|----------|--------|----------|----------|

Date

Claims Submitted Without Receipts:

| Start Date | End Date | Amount | Claimant | Provider |
|------------|-----------|---------|-----------|----------|
| 1/20/2011 | 1/20/2011 | \$60.00 | Doe, John | Dr |

[View Receipt Submittal Form](#)

Press “View Receipt Submittal Form”

This is your claim form. If you uploaded your receipts, please print this claim form and forward to administrator (see below) for processing. If you did not upload your receipts, please print this claim form and forward, along with receipts to administrator for processing.

Should you have any questions or require assistance, please do not hesitate to contact me.

Thank you,
Danielle Harrington

Email: dharrington@askcip.com

Tel: 617-354-0866 x 13

Fax: 617-354-1137

Please mail, fax or email claim form* and receipts (if receipts are not uploaded) to:

**Mail: Danielle Harrington
Comprehensive Benefit Services
799 Cambridge Street
Cambridge, MA 02141**

Fax: 617-354-1137

Email: dharrington@askcip.com

***Claim form must be submitted for processing.**