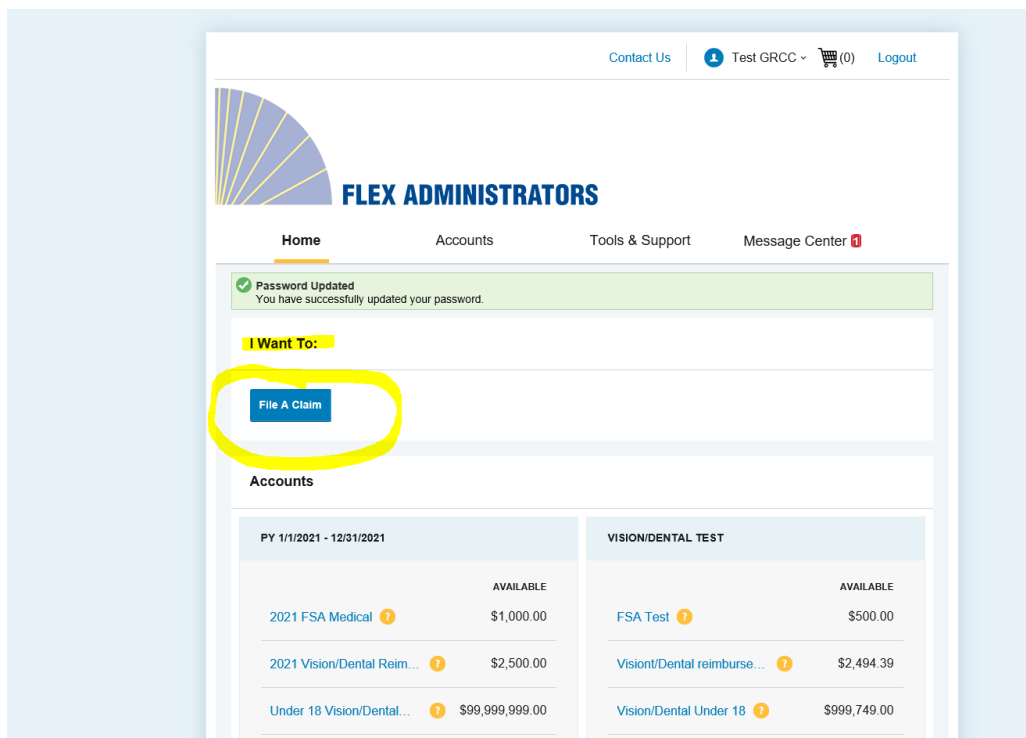


# Dental/Vision Reimbursement Online Portal Claim Submission Steps

## Top Tips to avoid delays:

- If filling your claim online/mobile app be sure to file each patient as a separate claim item – Do not lump dates of service and/or patients
- Ensure you're choosing the correct benefit type – I.E oral/flouride for children under the under 18 plan
- ASR is running out the 2020 Plan Year and all dates incurring in 2020 should be submitted through ASR.

**STEP 1:** After logging into your Online portal. Click File a Claim under “I Want To” on the HOME tab



**STEP 2:** Enter in the default selections

Pay From “Medical”

Pay to: “ME”. Click next.

Home   **Accounts**   Tools & Support   Message Center 1

## Accounts / File A Claim

**Available Balance**

2021 FSA Medical <span style="color: orange;">?</span>	2021 Vision/Dental R... <span style="color: orange;">?</span>	Under 18 Vision/Dent... <span style="color: orange;">?</span>	FSA Test <span style="color: orange;">?</span>
<b>\$1,000.00</b>	<b>\$2,500.00</b>	<b>\$99,999,999.00</b>	<b>\$500.00</b>

[More Accounts](#)

**Create Reimbursement** \* Required

Online claims filing is a fast and easy way to file claims. Just click the "File Claim" button next to the account you wish to use and start filing!

Pay From \*      Medical v

Pay To \* ?      Select a Payee... v

Based on your selection, you will be requesting a Claim Reimbursement.

Cancel
Next

**STEP 3:** Upload your itemized statement with proof of payment included by clicking Upload Valid Documentation and browsing for your document. Click upload and then Next when you are ready to move on.

Accounts / File A Claim

**Available Balance**

2021 FSA Medical <span style="color: orange;">?</span>	2021 Vision/Dental R... <span style="color: orange;">?</span>	Under 18 Vision/Dent... <span style="color: orange;">?</span>	FSA Test <span style="color: orange;">?</span>
<b>\$1,000.00</b>	<b>\$2,500.00</b>	<b>\$99,999,999.00</b>	<b>\$500.00</b>

[More Accounts](#)

**Receipt / Documentation** \* Required

Receipt(s) \* ?      [Upload Valid Documentation](#)

p502.pdf   [Remove Receipt](#)

[View Receipt\(s\)](#)

**Summary**

Pay From      Medical

Pay To      Me

Cancel
Previous
Next

**STEP 4:** Enter in your date of service, amount, provider name. (screen shot provided below)

**STEP 5:** To enter the category, choose the correct corresponding category by dropping down the box. If you are enrolled in the FSA, you will see your Dental and Vision Reimbursement Accounts as well as FSA expenses. Ensure you are choosing the correct field that you are requesting reimbursement from.

Start Date of Service \*  

End Date of Service  

Amount \* \$

Provider \*

Category \* 

Type \*

Description

If the category is 'Other' or 'Over-the-Counter Drugs', you must provide a description.

- Recipient \*  Test GRCC  
 Adult Child GRCC  
 Baby GRCC  
 Spouse GRCC

[Add Dependent](#)

### Summary

Pay From Medical

Pay To Me

Documentation Uploaded Yes

Start Date of Service *	01/05/2021
End Date of Service	1/5/2021
Amount *	\$ 200
Provider *	Dr. Crentist
Category * ?	Dental Reimbursement Plan
Type *	Dental Reimbursement Plan Drugs & Medicine FSA Dental FSA Vision Hearing Impairment Medical Expenses Mental Health, Chemical Dependency & Special Education Miscellaneous
Description	
Recipient *	<input type="radio"/> Test GRCC <input type="radio"/> Adult Child GRCC <input type="radio"/> Baby GRCC <input type="radio"/> Spouse GRCC
	<a href="#">Add Dependent</a>
<b>Summary</b>	
Pay From	Medical
Pay To	Me
Documentation Uploaded	Yes

Cancel Previous Next

**STEP 6:** After choosing your category/type, you list the patient name (shown here as recipient). NOTE: If requesting reimbursement for the Dental and/or Vision Reimbursement under the age of 18 benefit, you must choose that dependent's name to proceed.

Start Date of Service \* 1/5/2021

End Date of Service 1/5/2021

Amount \* \$ 200

Provider \* Dr. Crenst

Category \* Vision and Oral Exams for Under 18

Type \* Oral Exam/Fluoride under 18

Description

If the category is 'Other' or 'Over-the-Counter Drugs', you must provide a description.

Recipient \*  Test GRCC  
 Adult Child GRCC  
 Baby GRCC  
 Spouse GRCC

[Add Dependent](#)

**Summary**

From Medical

To Me

Documentation Uploaded Yes

Cancel Previous Next

**STEP 7:** Click “submit” to submit your claim. (you can also add other claims if needed).

Home Accounts Tools & Support Message Center 2

### Accounts / Transaction Summary

**Available Balance** **\*\* Balance reflects claims not yet submitted**

2021 FSA Medical \$1,000.00	2021 Vision/Dental R... \$2,500.00	Under 18 Vision/Dent... \$99,999,799.00 **	FSA Test \$500.00
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[More Accounts](#)

**Transaction Summary (1)**

FROM	TO	EXPENSE	AMOUNT	APPROVED AMOUNT	
+ Under 18 Vision/Dental Exams 2021	Me	Oral Exam/Fluoride under 18	\$200.00	\$200.00	Remove Update
<b>Total Amount</b>			<b>\$200.00</b>	<b>\$200.00</b>	

Cancel Save for Later Add Another Submit