Debit Card Receipts and Substantiation Process

Flexible spending account (FSA)
FSAs are funded with pre-tax dollars and regulated by the IRS. Due to IRS regulations, certain benefits debit card transactions need to be verified for eligibility, a process called substantiation. The IRS regulates the types of expenses on which you can spend your pre-tax dollars as well as the timeframe you have to use the funds. **Most plans allow you up to 200 days from the date of a charge to substantiate the transaction, if required. We will send you up to 3 reminders if you forget to send in your documentation.**

Substantiation requests

Scenario	Resolution
Documentation is needed to substantiate a benefits debit card transaction.	You'll receive an email notification to log in to your online account and view the receipt reminder.
You don't have an email address on file.	You'll receive a receipt reminder by mail.

The receipt reminder will include the date of the transaction, name of the provider or merchant, dollar amount, and allotted timeframe to submit the required documentation.

Temporary benefits debit card suspensions

Scenario	Resolution
You fail to provide the necessary documentation within the allotted timeframe noted on the receipt reminder.	Your benefits debit card may be temporarily suspended. Note: Most suspensions can be resolved by submitting the required documentation.
You cannot substantiate the charge.	You can pay back the plan or offset the ineligible amount with documentation for eligible out-of-pocket expenses incurred within the same plan year.
Funds were spent on ineligible expenses.	

Note: You typically still have access to file claims for reimbursement from your account while your benefits debit card is suspended.

Acceptable types of documentation
When documentation is requested, you're required to substantiate:

- Date service received or purchase made

- Description of service received or item purchased
- Dollar amount
- Provider or merchant name
- In some cases, a Medical Necessity Form or letter from your physician is required if the expense is considered both a medical expense and a general use item.

Note: An itemized receipt or statement from your provider or an Explanation of Benefits (EOB) from your insurance carrier typically has all the required information.

Submitting documentation

Important: Allow 7-10 business days for processing after your documentation is received. If your documentation is approved, your benefits card will be reactivated. You'll be notified if more information is needed.

Choose how to submit your substantiating documentation:

> Upload online
>
> Log in to your online account and upload your documentation to the Tasks section of the Home tab.
>
> Here is a video explaining how to upload your documentation using the consumer portal: https://www.screencast.com/t/axka8Aqk
>
> Upload via WEX benefits mobile app
>
> Download the free benefits mobile app on your Apple or Android device. Make sure you're using keyword search "Reimbursement by WEX" for our mobile app. Take a picture of your documentation using your device and submit it through the app.
>
> See How to upload documentation to an existing claim in the Benefits Mobile App for instructions. https://www.screencast.com/t/1DOD7sRIR
>
> Download and print the receipt reminder from your online account
>
> Fax: Send the receipt reminder and documentation to:
> 253-793-3766
>
> Mail: Send the receipt reminder and documentation to:
> WEX
> 1700 E Golf Rd Suite 1000
> Schaumburg, IL 60173

Understanding WEX benefits card auto-approval

The information below explains when WEX benefits card transactions are automatically approved and when you must provide documentation for eligible expenses.

Merchant category code (MCC)
The benefits card works in conjunction with an MCC network, which classifies businesses by the products they sell or services they provide. Only transactions at medical, dental, and vision providers or merchants are approved for plans that reimburse medical, dental, and vision expenses. Only transactions at parking and mass transit providers are approved for plans that reimburse Commuter Benefits expenses.

Scenario	Resolution
You're enrolled in more than one Benefits plan and swipe your benefits card at an eligible merchant or provider.	The MCC determines which account funds are pulled from.
You're enrolled in a medical flexible spending account (medical FSA) and swipe your benefits card at a doctor's office.	The transaction is approved because doctors' offices are coded as medical providers. Note: You may be asked for additional documentation after the charge is approved.
You swipe your benefits card at an ATM.	The transaction is declined because ATMs are coded as financial institutions.

Note: You can use your benefits card internationally, provided the merchant has an eligible MCC for the plan in which you're enrolled.

Inventory Information Approval System (IIAS)
Merchants can provide all IRS-required information right at the point of sale by using the IIAS. This computerized system allows the benefits card to recognize items being purchased. IIAS merchants auto-substantiate claims, so you don't need to provide additional documentation for eligible expenses. After you swipe your benefits card for the entire purchase, eligible items are approved, and the merchant will ask for a secondary form of payment for any ineligible items.

Scenario	Resolution
You try to purchase produce and Band-Aids with your benefits card.	The Band-Aids are approved, but the produce is declined because it's an ineligible expense.

The benefits card works at qualified medical, dental, vision, pharmacy, and IIAS locations. These typically include large retailers such as Wal-Mart, Target, Walgreens, CVS, and Amazon.
Other transactions often require additional substantiation because the providers don't have the IIAS in place:

- Hospitals
- Clinics
- Doctors' offices

- Dental providers
- Vision and optical facilities
- Pharmacies and drug stores without IIAS
- International merchants
- 90% merchants
  Note: These pharmacies and drug stores certify that at least 90% of their gross sales are from prescriptions or qualified over-the-counter (OTC) healthcare products.
- The benefits card is accepted regardless of the products purchased, so additional documentation will be required every time.

For a list of IIAS and 90% merchants, see SIGIS Store Locator.

Copays

If your employer provided us copay amounts during plan setup and a match occurs at the time your benefits card is swiped, transactions for these amounts are automatically approved. The system verifies whether the dollar amount matches a copay or multiple of a copay when you use your benefits card at an eligible provider.

Scenario	**Resolution**
You swipe your benefits card, and the dollar amount matches a copay for your health plan.	The charge auto-approves and we don't request documentation.

Note: Except for copays, benefits card transactions at medical, dental and vision providers will likely require additional documentation.

Recurring expenses

Recurring expenses are a series of eligible expenses that occur at the same provider and for the same dollar amount. You must submit documentation the first time you swipe your benefits card, but subsequent transactions at the same provider for the same amount are then automatically approved.

Scenario	**Resolution**
You see a chiropractor once a month, and you're charged the same amount each time.	You'll be asked to submit documentation for the first visit, but charges for all subsequent visits for the same amount are auto-approved.