# FLEXIBLE SPENDING ACCOUNT HEALTH REIMBURSEMENT ACCOUNT (FSA/HRA CLAIM FORM)

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MAIL CLAIM FORM TO: MEDICA FSA/HRA PO Box 981505 El Paso, TX 79998-1505 Fax: 915-231-1710 Member Services: Phone number on the back of your ID Card

Complete Part 1 entirely and legibly. If you do not know your Member ID, Group Number or a have a change of address please contact your benefit administrator.

Complete Part 2 if you are claiming medical, dental, vision, prescription or over-the-counter (must have a prescription for eligible OTC drugs or medicines; medical supplies do not require a prescription - including insulin) medication expenses.

Complete Part 3 if you are claiming dependent care expenses. Carefully read and follow the directions below regarding the Provider's Certification of Services Rendered.

DO

- Separate expense types by individual name.
- Complete the total requested amount.
- Include provider name, address and Tax ID (if available).
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts.
- Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form.
- Read Certification for Reimbursement, sign and date form.
- Make a copy of form and documentation for your personal records.

DO NOT

- Do not submit cancelled checks or credit card receipts alone. These are not adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite item names on receipts. These are not acceptable.
- Do not submit handwritten receipts for RX.
- Do not submit pre-treatment estimates or estimated insurance statements.

For Medical, Dental, Vision and Hearing Expenses, submit your insurance carrier's explanation of benefits (EOB) statement with your completed form. When applicable your insurance claim must be finalized prior to submitting for reimbursement. For expenses not covered by your medical, dental or vision insurance plan and for co-payments you must submit documentation which includes the following information:

\* Name of Provider \* Dollar amount charged \* Date of service \* Patient's name \* Type of Service \*Reason for non-coverage (Insurance Carrier EOB, if applicable)

Prescription documentation must contain the following:

\*Patient name \*Out of pocket cost of the drug \*Date the prescription was filled \*Prescription name or NDC # or the word copay must be printed on the receipt\* (Information usually can be found on prescription tags provided by pharmacies)

For Eligible Over-the-Counter (OTC) Drugs or medicines (requires a prescription to be reimbursable), or Eligible OTC medical care supplies (does not require a prescription – including insulin) you must check the OTC box on the claim form. Documentation must contain the following:

\*Printed receipt \*Name of the Over-the-Counter item \*Price \*Date of purchase \*OTC Prescription (only if OTC drug or medicine)

Dependent Care Services, if all four fields in the Day Care Provider's Certification section are completed, no further documentation is necessary. In lieu of the above submit a statement that includes:

\*Provider's name \*Provider's Tax identification or social security number \*Dates of service \*Cost of service

Mail (or fax) the form and required documentation to the address (or fax number) provided on this form. All reimbursement requests for a plan year must be postmarked prior to the filing deadline, which is specified in your plan documents. Please refer to your plan document for health related expenses that may not be reimbursable under your specific FSA plan. A general list of eligible/non-eligible items along with frequently asked questions are available on line at <a href="http://www.mymedica.com">www.mymedica.com</a>.

CDHP 03/13

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(FSA/HRA CLAIM FORM)				

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Part 1 Employee Information (Please Print) Please read the instructions in their entirety before completing form.

Employee Name (Last and First)	ALT ID or SSN	Date of Birth	Daytime Telephone No.
Mailing Address, City, State, Zip Code	Employer Name		
Please notify your benefits administrator of any addre			

#### Please notify your benefits administrator of any address changes.

Part 2 Health Care Expenses (please print). Itemize each expense using separate entries below. Use additional forms as necessary.									ecessary.				
Date of Service Patient Name / Relationship				Date of Birth						Description of Service	Amount		
From:													
Date of Service Name of Provider To:				Provider Phone #				#					
10.													
	Туре о	f Service <sup>1</sup>	(Please	check)									
MD	RX	OTC	VIS	DN	HR								
Date of From:	Service	Patient I	Name / F	elations	ship	Da	te of	Birth	า			Description of Service	Amount
Date of Service Name of Provider To:			Provider Phone #										
10.													
	Type o	f Service <sup>1</sup>	(Please	check)								4	
MD	RX	OTC	VIS	DN	HR							1	

<sup>1</sup>Please Check One Box For Each Expense Type: MD=Medical, RX=Prescription, OTC=Over-the-Counter, VIS=Vision, DN=Dental, HR=Hearing

#### Part 3 Dependent Care Expenses (Please Print) itemize each expense using a separate line. Use additional forms as necessary.

Dependent/Child's Name	Relationship	Date of Birth mm/dd/yyyy	Type of Dependent/Child Care Service	Date(s) of Service mm/dd/yyyy		Request Amount
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		/ /		From:	To:	
		L	Dependent/Chi	ld Care Exp	enses Subtotal	
			Total Req	uest For R	eimbursement	\$
Day Care Provider's Certifica			RINT)	arges incur	red have been pr	ovided for

Day Care Provider and Company Name:	Day Care Provider's Address:
Day Care Provider's Tax Id#:	Day Care Provider's Signature and Title:

### **Certification For Reimbursement**

I certify that any expenses for which I am requesting reimbursement from my Health Care/Dependent Care FSA, as itemized above, were incurred by me (and / or my spouse and / or eligible dependents) for medical care as permitted under the Health Care/Dependent Care FSA, and have not been reimbursed and I will not seek reimbursement under any other plan. I understand that expenses reimbursed through the FSA program cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements are complete and true.

## EMPLOYEE SIGNATURE: