HIGHMARK Delaware

Health Reimbursement Arrangement (HRA) Claim Form

INSTRUCTIONS:

1. Please see the reverse side for instructions on completing this claim form.
2. To avoid delays in processing, please complete all fields, and attach your Explanation of Benefits (EOB) statement.
3. Your signature is required.
4. Please retain a copy of this completed form and documentation for your records.

Reimbursement of claims are subject to the provisions of your employer's plan design and applicable laws and regulations.

Employee's Name - Last, First, Middle Initial	**Employee's Social Security Number**	**Email Address**

Address ❑ Check this box if this is a new address.

Daytime Telephone Number - Include Area Code	**Employer**

Use this form to request reimbursement only for services covered by your Employer's HRA.

If you have any questions:

Visit: highmarkbcbsde.com (select Pre-Tax Benefits Program)
Email: Flex@bcbsde.com
Call: 302.421.8970 or 800.559.FLEX (3539), 8:00 AM-5:00 PM (ET), Monday-Friday
Fax: 302.421.8883

PROVIDER OF SERVICE	PERSON RECEIVING SERVICE	BIRTH DATE	RELATIONSHIP	DATE OF SERVICE FROM - TO	EXPENSE TYPE CODE*	REIMBURSEMENT REQUEST AMOUNT
		/ /				$
		/ /				
		/ /				
		/ /				
		/ /				

Expense Type Codes:
D = Dental
H = Hearing**
HC = Health
P = Prescription Drugs**
V = Vision**
***If allowed by plan design*

Total Reimbursement Requested:
(Minimum Total of $50.00) $

I CERTIFY THAT:

1. The health care expenses claimed above are not eligible for payment or reimbursement by any employer-sponsored health care program.
2. The expenses claimed above have not been paid or reimbursed by, and have not been and will not be submitted for payment or reimbursement by, any other plan covering health benefits, including but not limited to any individual or group health insurance or any other health care flexible spending account, including coverage under a spouse's or dependent's plan.
3. Any expenses claimed above for a person other than myself were incurred by an individual who was my spouse or dependent child at the time the expense was incurred.
4. The expenses claimed above have not been and will not be taken as a deduction on my federal income tax return for the year paid or incurred.
5. The expenses, claimed above are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and are not cosmetics or toiletries.
6. Expenses incurred in one plan year may be reimbursed in a later plan year only if the employer's plan documents so provide, and if **(a)** the employee was covered under the employer's HRA when the expense was incurred; and **(b)** if the expense was for a spouse and/or a dependent child, such individual was the spouse and/or child of the employee at the time the expense was incurred.

Signature: _____ **Date:** _____/_____/_____

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a claim containing any false, incomplete or misleading information may be guilty of a felony.

Attach copies of the required documentation to this form and send to:

Highmark Blue Cross Blue Shield Delaware
Flexible Benefits Department
P.O. Box 8737
Wilmington, DE 19899-8737

INSTRUCTIONS FOR COMPLETING HRA REIMBURSEMENT CLAIM FORM

Questions? Please contact us using the information below.

Visit highmarkbcbsde.com (select *Pre-Tax Benefits Program*) **Fax:** 302.421.8883 **Email:** Flex@bcbsde.com

Call: 800.559.FLEX (3539), Monday-Friday, 8:00 AM to 5:00 PM (ET)

To prevent delays in processing your claims, please complete this form correctly.

Name, Social Security Number, Address: Enter your name, Social Security number and address as it appears on your employer's payroll records.

Daytime Telephone Number: Enter your daytime telephone number.

Employer: Enter the name of your employer.

Provider of Service: Enter the name of the person or facility that provided the service: for example, the doctor or pharmacy. Use a separate line for each expense.

Person Receiving Service: Enter your name, or if you're completing the form your spouse or dependent child, his or her name.

Birth Date: Enter the birth date of the person receiving the service.

Relationship: Enter the dependent's relationship to you: for example, your daughter, son or spouse.

Date of Service: Enter the date the service was incurred, not the date it was paid. **NOTE:** For medical supplies, the incurred date may be the date the expense was paid.

Expense Type Code: Enter the code for the type of expense incurred:

D = Dental
H = Hearing
HC = Health Care
V = Vision
P = Prescription Drugs

Reimbursement Request Amount: Enter the amount of the incurred expense that is eligible for reimbursement. This must agree with the documentation submitted.

Total Reimbursement Request: Add the amounts of reimbursement requested and enter the total. The total must be a minimum of $50, unless your account balance is less than $50.

Signature and Date: Sign and date the form. Un-signed claim forms will delay processing.

Documentation Required: For health, dental or vision care expenses, attach a copy of the Explanation of Benefits (EOB) statement, denial letter or other documentation you received from the insurance company(ies) or the provider of service, if insurance is not involved (where allowed by plan design). The documentation must include the name of the provider, the name of the person receiving the service, the type of service, the incurred date and the provider's charge for the service. (Credit card receipts or cancelled checks are not acceptable forms of documentation.)

For prescription drug expenses, attach a prescription statement from the pharmacy with the name of the prescription and/or prescription number as well as date dispensed (not just a receipt of payment). Example: a bag receipt with prescription number, which includes the name of the medicine; or the medicine category such as antacid or pain reliever; the date of purchase and amount paid.

If allowed by your plan and effective January 1, 2011, over-the-counter medicines (OTC) require a prescription in order to be considered for reimbursement.

Documentation for an OTC medicine claim must include:

- A prescription for such medicine, or an electronic or written order for a medicine that meets the legal requirements of a prescription in the state in which the medical expense is incurred; and
- A participating statement indicating that the medicine was purchased for the employee, spouse or dependent.

Send the completed form with documentation attached to:

Highmark Blue Cross Blue Shield Delaware
Flexible Benefits Department
P.O. Box 8737
Wilmington, DE 19899-8737