HIGHMARK Delaware

Health Flexible Spending Account (FSA) Claim Form

INSTRUCTIONS:
1. Please see the reverse side for instructions on completing this claim form.
2. Please PRINT all requested information (except signature).
3. Please retain a copy of this completed form and documentation for your records.

PAYMENT OR REIMBURSEMENT OF HEALTH FSA CLAIMS ARE SUBJECT TO THE PROVISIONS OF YOUR EMPLOYER'S PLAN DOCUMENT 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**

- The terms health care expenses, claims, insurance and employer-sponsored health care program include expenses, claims, insurance and employer-sponsored programs for medical, dental, vision and prescription drugs.
- Use this form to request reimbursement only for the following:
  1. Expenses not covered by any health insurance; and
  2. The unpaid balance of a health care claim, including, but not limited to, any copayments, coinsurance or deductibles.

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 for questions or Claims: 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 Care, MS = Medical Supplies, OTC = Over-the-Counter Medicines, P = Prescription Drugs, V = Vision

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.

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 HEALTH FSA 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: 302.421.8970 or 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 and His/Her Social Security Number: Enter your name, or if completing the form for your spouse or dependent child, his or her name, and the individual's Social Security number.

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

Relationship: If completing the form for a dependent, enter the dependent's relationship to you: For example, your daughter, son or spouse.

Date Expense Incurred: Enter the date the expense was incurred, not the date it was paid. NOTE: For medical supplies and over-the-counter (OTC) medicines, 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
MS = Medical Supplies
OTC= Over the Counter Medicines
P = Prescription Drugs
V = Vision

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

Total Reimbursement Requested: 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.

Documentation Required: You must attach copies of the required documentation to receive reimbursement.

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. 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.

For OTC Medicine Claims: The following documentation is required for medicines and drugs that either (a) were available previously only by prescription, such as antibiotics, or (b) are commonly recognized as medicines or drugs, such as antacids, pain relievers, allergy medicines, cold medicines, etc.

Documentation for an OTC medicine claim must include:

- A prescription for such medicines, defined as an electronic or written order for a medicine that meets the legal requirements of a prescription in the state in which the medicine expenses is incurred; and
- A participant statement indicating that the medicine was purchased for the employee, spouse or dependent; and
- An adequate receipt that includes the name of the medicine, or the category, such as antacid, pain reliever, etc., the date of the purchase and amount paid.

For OTC Medicine Claims that could be Dual Purpose: The following documentation is required for medicines that could be for an individual's general well-being, as well as medical purposes:

- A prescription for such medicines and a statement from a physician establishing that the individual has a medical condition, and that the medicine expense is for a medicine that treats the individual's medical condition; and
- A participant statement indicating that the medicine was purchased for the employee, spouse or dependent; and
- An adequate receipt that includes the name of medicine, or the category, such as antacid, pain reliever, etc., the date of purchase, and the amount paid.
  - An example is sunscreen. An individual would need to provide a note from a physician stating that the individual had/has skin cancer and thus must use sunscreen to prevent further skin cancers. The physician's note would establish the existence of a medical condition.

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