Spending Account Processing

Health Reimbursement Account Form

(Do not fax or mail this instruction page)

This form is used to request reimbursement for health care expenses only. All health care expenses may be first submitted to your health care plan or any other health care coverage that you may have. Please note the following instructions:

- Use this form to request reimbursement of expenses incurred during the plan year.
- If you are submitting expenses for more than one plan year, you can submit a separate form for each year that you are an eligible participant. Complete all information, and be sure to sign the Self Certification in Section 3.
- Each expense you submit must be properly documented.

Option 1: ***Go Paperless!*** You won't need to complete paper forms anymore. Just submit claims online!

Option 2: Submit your claim using this form.

Step 1: Complete the form

- *Please print in capital letters, with the letters centered in the boxes as shown:*

A	B	C	D		1	2	3	4

- *Complete a separate line for each individual expense.*
- *Use page 3 if you exceed the number of lines available on page 2.*

Step 2: Attach Supporting Documentation

- *See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable by the IRS.*
- *Do not send original receipts or supporting documentation.*
- *Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.*

Step 3: Certify

- *Read the Certification and then sign and date the form.*

Step 4: Submit

- **FAX** *the form and supporting documentation to* **1.866.228.9417**.
- *Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.*
- *Alternatively, you may also mail your claims to:*

  Spending Account Processing
  PO Box 25173
  Lehigh Valley, PA 18002-5173

  To expedite processing, please send only one claim and supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

Remember: *Keep a copy of the form and all original receipts for your records.*

Type of Supporting Documentation

- Copy of itemized receipts from your pharmacy or medical/dental/vision provider.
- Copy of Explanation of Benefits (EOB) from your insurance company or health care provider.
- Must show:
  - Date(s) of service(s) or purchase.
  - Type of service or name of product.
  - Amount (paid by you).
  - Name of person or organization providing the service or product.
- Cancelled checks or payment statements are not considered acceptable evidence.
- Prescriptions for **over-the-counter (OTC) medications** must show the purchase date and the name of the medicine or drug.
- An EOB form is not required for eligible OTC medications.

Please Do

- For multiple expenses on one receipt for the same expense code, use one line to show a total of such expenses (e.g., several over-the-counter items, multiple prescription copays listed on one receipt).
- For expenses that belong to different expense codes or are on different receipts, use one line per expense.
- Use additional copies of Page 3 if your expenses exceed the number of lines available on Pages 2 and 3.
- Be sure to print legibly and use capital letters.

Please Do Not

- Fill out the form using red or blue ink.
- Highlight receipts or any part of the form.
- Send original receipts.
- Staple copied receipts to the form.
- Write outside of the boxes provided.
- Submit the same claim more than once.
- Fax or mail this Instruction Page.

List of Expense Codes – Sections 2 and 5 of the form need to specify the type of expense using one of the following:

Medical
101 = Ambulance
102 = Co-Insurance
103 = Deductible
104 = Doctor
105 = Equipment
106 = Hospital
107 = Laboratory
108 = Pharmacy Prescription
109 = Related Travel
110 = Therapy

Medical – OTC
111 = Over-the-Counter Medication

Medical – Preventative
201 = Immunization
202 = Physicals
203 = Screening
204 = Smoking Cessation
205 = Weight Loss

Dental
301 = Equipment
302 = Examination
303 = Orthodontia
304 = Over-the-Counter Medication
305 = Pharmacy Prescription
306 = Treatment

Vision
401 = Equipment
402 = Examination
403 = Over-the-Counter Medication
404 = Pharmacy Prescription
405 = Treatment

Health Reimbursement Account Claim Form

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FAX TO: 1.866.228.9417
or Mail to: Spending Account Processing Center
PO Box 25173, Lehigh Valley, PA 18002-5173

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)

PARTICIPANT ID or UMI

EMPLOYER or GROUP NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

PARTICIPANT EMAIL

DAYTIME PHONE # (AREA CODE FIRST - NO DASHES)

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS)

EXPENSE 1
EXPENSE CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT
$.

PROVIDER NAME

TO (MMDDYY)

SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 2
EXPENSE CODE

DATES OF SERVICE
FROM (MMDDYY)

AMOUNT
$.

PROVIDER NAME

TO (MMDDYY)

SERVICE PROVIDED TO (NAME & RELATIONSHIP)

SECTION 3: SELF CERTIFICATION

I certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the program, and that these expenses have not been reimbursed or are not reimbursable under any other plan/program. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I agree to abide by the terms of the program and have read the information on this form. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

EMPLOYEE SIGNATURE:* _____ DATE: _____

*Your signature is required in order to process your claim for reimbursement

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or Mail to: Spending Account Processing Center
PO Box 25173, Lehigh Valley, PA 18002-5173

SECTION 4: YOUR INFORMATION (ABBREVIATED) (Use only CAPITAL LETTERS)

PARTICIPANT ID or UMI

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

SECTION 5: YOUR EXPENSES

EXPENSE 3
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
AMOUNT
$.
PROVIDER NAME
TO (MMDDYY)
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 4
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
AMOUNT
$.
PROVIDER NAME
TO (MMDDYY)
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 5
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
AMOUNT
$.
PROVIDER NAME
TO (MMDDYY)
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 6
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
AMOUNT
$.
PROVIDER NAME
TO (MMDDYY)
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 7
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
AMOUNT
$.
PROVIDER NAME
TO (MMDDYY)
SERVICE PROVIDED TO (NAME & RELATIONSHIP)