Flexible Spending Account Claim Form Instructions

(Do not fax or mail this instruction page)

Options: ***Please use option 1 for faster reimbursement***

1. Online: Log in to your account. Submit your claim online and attach the image or scanned copy of your receipt.

2. Fax or Mail: Enter the claim online, then print the online fax cover sheet and submit the cover sheet and receipt through Fax or Mail. Otherwise complete and sign this claim form attaching the copy of your receipt and submit through Fax or Mail.

Fax: **1.866.228.9417**

Mail: **Spending Account Processing**

PO Box 25173, Lehigh Valley, PA 18002-5173

-- Please make sure that you fax or mail the claim form and the related supporting documentation together. The claim form should be the first page in the stack of pages that you fax.

Instructions:

• Please print or write in capital letters, with the letters centered in the boxes

• Complete all information of " Your Information"- Section 1

• Use your documentation to complete "Your Expenses"- Section 2 of the form, including the following:

1. Doctor or service provider name

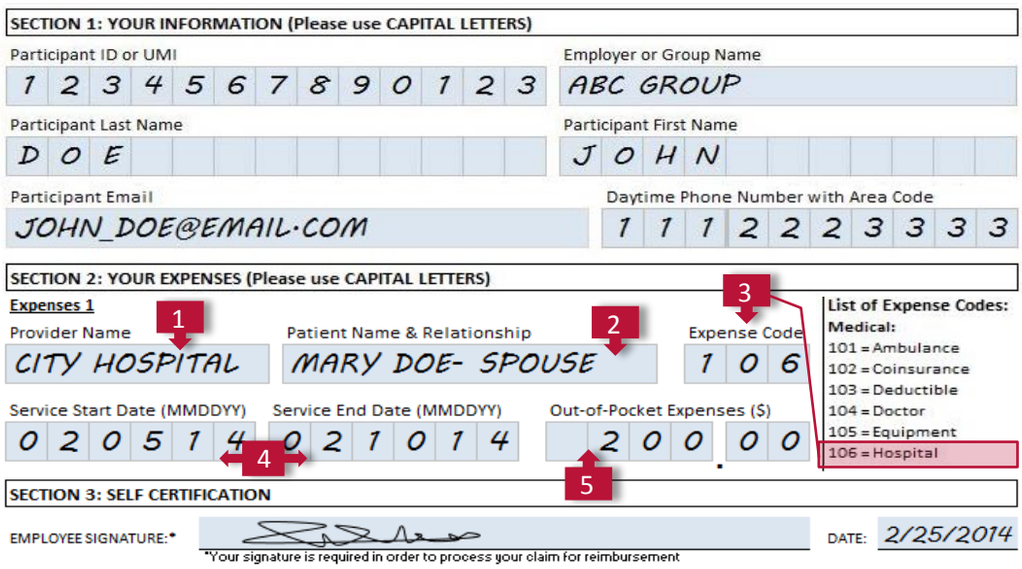
2. Patient name & relationship to participant

3. Medical expense code from list to the right

4. Service start & end dates

5. Your out-of-pocket expenses. These are the costs you paid.

• Read the certification of Section 3 and Sign and date the form



Acceptable Supporting Documentation:

• Copy of Explanation of Benefits(EOB) from your insurance company

• Copy of detailed receipts from your pharmacy, medical, dental or vision provider. Your receipts must show:

- The date you received the service or the date you made a purchase.
- Service type or product name. Check eligible service or product list online. Some products and services require a letter of medical necessity from your doctor for example massage therapy or wellness service.
- Amount charged to patient clearly showing the patient's responsibilities.
- Doctor or service provider name

Unacceptable Supporting Documentation:

• Credit or debit card receipts, canceled checks or other payment statements are not accepted as support documentation.

• Documentation showing a previous balance or Balance forward amount

• Prepayments, pretreatment estimates or estimated insurance statement are not acceptable documentation.

• Original receipts or supporting documentations. Keep originals for yourself and send copies.

Notes:

• **While submitting any Orthodontia claims** for the first time, please submit the orthodontia contract from the orthodontist along with any proof of payment (such as Credit Card receipt, Cancelled Check etc.).

• **Receipts for over-the-counter (OTC) medications or items** must show the purchase date and the name of the medicine or item. Please circle the expense on your receipt. A valid prescription is required for most of the OTC medications (for example Cough & Cold drops, Pain relief drugs, allergy medicine) to get approved. But for insulin, diabetic supplies, OTC medical devices (crutches, blood sugar monitors, blood pressure monitors), bandages, contact lens solutions, etc. don't need prescriptions.

Flexible Spending Account Claim Form

Fax to: 1.866.228.9417

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

Go Paperless! You won't need to complete paper forms anymore. Submit online and expedite reimbursement.

SECTION 1: YOUR INFORMATION (Please use CAPITAL LETTERS)

Participant ID or UMI

Employer or Group Name

Participant Last Name

Participant First Name

Participant Email

Daytime Phone Number with Area Code

SECTION 2: YOUR EXPENSES (Please use CAPITAL LETTERS)

Expenses 1

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

Expenses 2

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

Expenses 3

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

Expenses 4

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MMDDYY) | Service End Date (MMDDYY) | Out-of-Pocket Expenses ($)

More expenses? Please complete another claim form.

List of Expense Codes:

Medical:
101 = Ambulance
102 = Coinsurance
103 = Deductible
104 = Doctor
105 = Equipment
106 = Hospital
107 = Laboratory
108 = Pharmacy Prescription
109 = Related Travel
110 = Therapy
111 = Over The Counter (OTC)

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

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

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.