HOW TO FILE YOUR HEALTH CARE ACCOUNT REIMBURSEMENT CLAIM

This form is to be used to **request reimbursement for health care expenses only**. To view a detailed list of eligible medical expenses, visit www.myshps.com. All health care expenses should first be filed under your employer's health care plan or any other coverage you may have. Generally, eligible expenses include: allowable expenses covered but not fully reimbursed by any benefit plans, such as co-payments; and allowable expenses NOT covered by any benefit plans, such as over-the-counter medicines.

Step 1: Fill out the form

- Please print in capital letters, with your letters centered in the boxes provided and fill in all ovals as shown:

A	B	C	D		1	2	3	4

● YES ○ NO

- Complete all sections of the claim form. Sign and date the bottom of the form.
- If your claims exceed the number of lines provided, please use page 3.

Step 2: Attach supporting documentation

- Copy your receipts or other supporting documentation onto a white, letter-sized sheet of paper. Place your receipts so they all face the same direction. And write your Social Security Number or employer ID at the top of the page.

Step 3: Submit your claim (Faxing is faster)

- By Fax: Send the claim and copied receipts as one multi-page fax. Do not include a fax cover sheet. If you provide your e-mail address, SHPS will e-mail you confirmation we received your claim.
- By Mail: Place the form and the supporting documentation into an envelope, apply the correct postage, and mail.
- Keep a copy of your completed claim form and receipts throughout the plan year.

Step 4: Receive your reimbursement (Direct Deposit is faster)

- By using Direct Deposit or Electronic Funds Transfer (EFT), you'll receive your reimbursement funds up to five days faster than by receiving a check. To sign up, log in to your account at www.myshps.com and select "Direct Deposit Sign-Up" from the left-side menu.

Type of Supporting Documentation:

- Itemized receipt from your medical, dental or vision provider or pharmacy
- Itemized receipt for over-the-counter medicines–must show the name of the product
- Explanation of Benefits (EOB) from your insurance company
- Documentation must show:
  - Date of service or purchase
  - Type of service or name of product
  - Amount (your portion of payment)

Please Do Not:

- Use red ink
- Use a photocopy of the form
- Highlight receipts or any part of the claim form
- Staple your copied receipts to the claim form
- Write outside the boxes provided
- If faxing, fax the same claim more than once
- Mail the same claim that you have faxed
- Include this instruction sheet with your fax

COVERAGE CODES – You must include a code on Section 2 of the form.

Medical codes

101 = over-the-counter medicines

102 = co-pays

103 = prescriptions or prescription co-pays

104 = massage therapy

105 = counseling/psycho therapy

106 = in-patient hospital expense

107 = chiropractic/physical therapy

108 = vitamins and supplements*

109 = weight management

110 = general medical

111 = cosmetic surgery & procedures*

112 = orthotics

113 = electrolysis/hair restoration*

199 = Other medical

Dental codes

201 = orthodontia

202 = teeth whitening/bonding/veneers*

203 = general dental (cleanings, check-ups, x-rays, crowns, implants, exams, dentures, etc.)

299 = other dental

Vision codes

301 = vision expenses

302 = non-prescription sunglasses*

Other codes

999 = other

*Note: * indicates items that are generally not eligible health care expenses.*

New IRS Tax Dependent Definition:

A recent change to the Internal Revenue Code revised the definition of "dependent." Generally speaking, a qualifying child must reside with you for more than half the year and must not provide over half of his/her own support. A qualifying relative is an eligible individual if (1) you provide more than half of the individual's support, and (2) the individual is not a qualifying child of you or any other taxpayer. **Please note that any questions regarding the status of an individual as either a qualifying child or a qualifying relative must be discussed with a qualified tax advisor in conjunction with the provisions of your employer's plan.**

Questions? Go to www.mySHPS.com or call SHPS Customer Service at 1-877-358-4276.

REIMBURSEMENT CLAIM FORM – HEALTH CARE EXPENSES

Use only CAPITAL LETTERS, completely fill in ovals, and don't use red ink.

FAX CLAIMS TO: 866-643-2219 TOLL FREE

For additional claim requests, please use next page.

XHCXRX

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID

COMPANY NAME

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

FOR SHPS ONLY

EMPLOYEE EMAIL

DAYTIME PHONE #

SECTION 2: YOUR HEALTH CARE CLAIMS

CLAIM 1

COVERAGE TYPE (SELECT ONE)

- MEDICAL
- ORTHO
- DENTAL
- OTC
- VISION

DATES OF SERVICE (MMDDYY)

FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

COVERAGE CODE (SEE LISTING)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

CLAIM 2

COVERAGE TYPE (SELECT ONE)

- MEDICAL
- ORTHO
- DENTAL
- OTC
- VISION

DATES OF SERVICE (MMDDYY)

FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

COVERAGE CODE (SEE LISTING)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

CLAIM 3

COVERAGE TYPE (SELECT ONE)

- MEDICAL
- ORTHO
- DENTAL
- OTC
- VISION

DATES OF SERVICE (MMDDYY)

FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)

$.

COVERAGE CODE (SEE LISTING)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

SECTION 3: CERTIFICATION

Please read Certification Statement thoroughly before signing.

I hereby certify that:
- The information contained within this claim is correct; and
- I have not received reimbursement previously for these expenses from my Flexible Spending Account or any other plan and will not seek reimbursement by any other plan.

I understand that:
- Reimbursement is not a guarantee that this payment is tax free; and
- Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Flexible Spending Account.

I hereby authorize SHPS or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Flexible Spending Account.

FAX: 1-866-643-2219 Toll Free

MAIL: SHPS FSA Administration
PO Box 34700
Louisville, KY 40232

PHONE: 1-877-358-4276

Employee Signature ______________________ Date ____________

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USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

USE THIS PAGE FOR ADDITIONAL HEALTH CARE CLAIMS.

BHBABDB

SECTION 4: YOUR INFORMATION (ABBREVIATED)

SOCIAL SECURITY NUMBER OR EMPLOYEE ID

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

SECTION 5: YOUR ADDITIONAL HEALTH CARE CLAIMS

CLAIM 4
COVERAGE TYPE (SELECT ONE)
MEDICAL
ORTHO
DENTAL
OTC
VISION
DATES OF SERVICE (MMDDYY)
FROM
TO
REQUESTED AMOUNT (DOLLARS . CENTS)
$.
COVERAGE CODE (SEE LISTING)
COVERED BY INSURANCE?
YES NO
EOB ATTACHED?
YES NO

CLAIM 5
COVERAGE TYPE (SELECT ONE)
MEDICAL
ORTHO
DENTAL
OTC
VISION
DATES OF SERVICE (MMDDYY)
FROM
TO
REQUESTED AMOUNT (DOLLARS . CENTS)
$.
COVERAGE CODE (SEE LISTING)
COVERED BY INSURANCE?
YES NO
EOB ATTACHED?
YES NO

CLAIM 6
COVERAGE TYPE (SELECT ONE)
MEDICAL
ORTHO
DENTAL
OTC
VISION
DATES OF SERVICE (MMDDYY)
FROM
TO
REQUESTED AMOUNT (DOLLARS . CENTS)
$.
COVERAGE CODE (SEE LISTING)
COVERED BY INSURANCE?
YES NO
EOB ATTACHED?
YES NO

CLAIM 7
COVERAGE TYPE (SELECT ONE)
MEDICAL
ORTHO
DENTAL
OTC
VISION
DATES OF SERVICE (MMDDYY)
FROM
TO
REQUESTED AMOUNT (DOLLARS . CENTS)
$.
COVERAGE CODE (SEE LISTING)
COVERED BY INSURANCE?
YES NO
EOB ATTACHED?
YES NO

CLAIM 8
COVERAGE TYPE (SELECT ONE)
MEDICAL
ORTHO
DENTAL
OTC
VISION
DATES OF SERVICE (MMDDYY)
FROM
TO
REQUESTED AMOUNT (DOLLARS . CENTS)
$.
COVERAGE CODE (SEE LISTING)
COVERED BY INSURANCE?
YES NO
EOB ATTACHED?
YES NO

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)