COVENTRY CONSUMER CHOICE℠

COVENTRY Health Care

FSA or HRA Reimbursement Form

(See instructions on reverse side) ☐ 1st submission ☐ Adjustment ☐ Appeal

EMPLOYEE INFORMATION – MUST BE COMPLETED (Please Print)

Employee's Name (Last, First, MI) _____ Member ID Number _____ Group Number _____

Address _____ City _____ State _____ Zip Code _____ Daytime Phone Number (_____)_____

HEALTH CARE EXPENSES (FSA or HRA) – MUST BE COMPLETED (see instructions on reverse)

Patients Name	Date of Service From	Date of Service To	Type of Service *(i.e. copays, deductible, coinsurance, member responsibility)*	Provider Name *(i.e. physician, hospital, dentist, pharmacy)*	Send Reimbursement to Employee or Provider?	Do you have other coverage for this service (attach EOB)	Amount of Expense to be Reimbursed
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
			Total reimbursement requested from your **Coventry Consumer Choice Account**				$

DEPENDENT CARE EXPENSES – MUST BE COMPLETED (see instructions on reverse)

1. Dependents Full Name	Dependent's Birth Date	Date of Service From	Date of Service To	Amount of Expense
Provider Name & Address		Provider Tax ID Number		

Provider Signature:_____ Signature not required if signed receipt or invoice is attached

2. Dependents Full Name	Dependent's Birth Date	Date of Service From	Date of Service To	Amount of Expense
Provider Name & Address		Provider Tax ID Number		

Provider Signature:_____ Signature not required if signed receipt or invoice is attached

3. Dependents Full Name	Dependent's Birth Date	Date of Service From	Date of Service To	Amount of Expense
Provider Name & Address		Provider Tax ID Number		

Provider Signature:_____ Signature not required if signed receipt or invoice is attached

Total amount requested from your **Dependent Care Flexible Spending Account**	$

*** I hereby certify that:**

- **The information given on this reimbursement form is complete and correct.**
- **I have not received reimbursement for these expenses from the reimbursement account or from any other source.**
- **The total of reimbursed dependent care expenses does not exceed the lesser of my or my spouse's earned income (W-2 pay) for the year, if less than $5,000.**
- **All health and dependent care expenses listed above comply with requirements and guidelines listed on page 2 of this form.**

This authorizes my insurance company, prepayment organization, employer, hospital, physician, or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

*X*_____ _____/_____/_____

Employee Signature (If submitted without signature claim(s) will be denied) Date FHRF 1007

Mail your completed form to: Coventry Consumer Choice, PO Box 7760, London, KY 40742 or fax to (606) 330-1379

Instructions:

1. Complete Employee Information section (please print).
2. Complete Health Care and/or Dependent Care Expense section as appropriate. Service must be incurred before being reimbursed.
3. Attached all required supporting documentation.

Supporting Documentation: The type of documentation described under either A or B below **must** be attached to the completed form.

A. Explanation of Benefits form (EOB): This is the form you receive each time you or a health care provider submit claims for payment to your health, dental, or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental, or vision care plans, you **must** attach an EOB.

B. All other Expenses: For expenses not covered at all by your (or your spouse's) health, dental, or vision care plans, reimbursement request **will not be processed** without acceptable evidence of your expenses. A canceled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain the following information:

- Name of person for whom the service/supply was provided
- Date expense was incurred
- Type of service (i.e., copay, deductible, coinsurance, dental, vision, RX, over the counter drugs)
- Name of provider (i.e., physician, hospital, dentist, pharmacy)
- Amount of expense(s)

4. If you have both FSA and HRA, funds will be deducted first from the FSA based on the plan design selected by your employer.
5. If reimbursement should be sent directly to the provider, please provide name, address (including city, state & zip code) and taxpayer identification number.
6. **Sign and Date the form (if submitted without employee signature claim(s) will be denied.)**
7. Please make copies for your records, as these documents will not be returned.
8. Mail the completed form and attachment(s) to: **Coventry Consumer Choice, PO Box 7760, London, KY, 40742 or fax to (606) 330-1379.** If you fax your claim(s), keep the original and the receipt fax showing time and date for tracking purposes.
9. If you have any questions regarding your reimbursement account or claims. Please call the customer service number or visit the member website address located on the back of your medical ID card.
10. Paper checks will not be distributed until accumulated reimbursement amounts exceed $25.
11. Electronic fund transfers (i.e. direct deposit) will be deposited directly into the designated bank account regardless of reimbursement amount.

Dependent Care Requirements:

In order for your dependent care expenses to be reimbursed from the flexible spending account, the expenses must meet all plan and IRS requirements. Please review your plan documents carefully to determine whether an expense meets the plan requirements. Reimbursement of dependent care expenses will reduce and may eliminate completely your ability to claim dependent care credit on your federal income tax return.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this plan.
- Reimbursement will only be made in accordance with the provisions of the plan. You accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.