Reimbursement Request Form

OneExchange™
from Towers Watson

Mail to: P.O. Box 2396 Omaha, NE 68103-2396 Fax to: 1-855-321-2605

① Former Employer Name | Total Number of Pages

Account Holder Name – Last | First | Middle

Social Security Number ___ - ___ - ____ Zip Code _____

②

Date of Service MM/DD/YY	Type of Coverage	Covered Participant Name	Relationship e.g. self	Amount Requested
01/01/2014	Medical	John Doe	Spouse	$XXX.XX
			Total Amount Requested	

③ By signing below, I certify that the information provided on this reimbursement request form is correct and that the expenses for which I am requesting or for which I am providing validation: were incurred for premiums for the covered participant under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement.

Account Holder Signature | Date

④ To qualify for your reimbursement you must provide a third party document that includes the information to the right.

Please CHECK ☑ Each Reimbursement Request Qualification as you complete them.

☑ **Does your documentation cover these items?**

- ☐ Covered Participant's Name (John Doe)
- ☐ Providers Name (e.g., AARP)
- ☐ Date of Service (1/1/2014)
- ☐ Description of Coverage (Medigap)
- ☐ Proof of Payment

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Guide to Requesting Reimbursement

To request reimbursement for your health care expenses use this form.

① **Account Holder Information:** The Account Holder is usually the retiree or the surviving spouse.

② **Reimbursement Request Information:** Complete this section to indicate the covered participant and relationship to the account holder; Date of Service; Type of Coverage (e.g., Medical); and Amount Reimbursement Requested (should be the entire expense you incurred/paid.

③ **Certification Requirement:** Carefully read the certification requirements before signing.

④ **Premium Reimbursement Requests** – To file a request for a health premium (e.g., medical), you must provide supporting documents from a third party (e.g., health carrier) to certify the request.

A premium statement AND a bank statement, or a canceled check or premium statement showing the amount paid, should include all of the required information.

The payment amount must match the amount on the premium statement.

When submitting a request for your premium reimbursement, the coverage period start date should be used as the date of service, not the date of payment.

For Medicare premiums deducted from your Social Security disbursement, please include the "Proof of Income Letter" from the Social Security Administration, sometimes called a budget, benefits, or proof of award letter.

Requests for future premiums can be submitted with this form as long as the future premiums have been paid. With this form Medicare premiums must be submitted each month.

Out of Pocket Reimbursement Requests – To file a request for an out of pocket expense (e.g., copay, deductible, coinsurance), you must provide proper supporting documentation from a third party (hospital, doctor, pharmacy) to qualify for the reimbursement.

☑ Please CHECK Each Reimbursement Request Qualification – To qualify you must provide a third party document that includes the following information:

☐ Name of the Provider
☐ Description of the Service or Product
☐ Date of Service or Purchase
☐ Patient Name
☐ Amount Paid or Owed After Insurance

An Explanation of Benefits (EOB) from your health insurance carrier will typically include all of the required information. Other documents such as receipts and statements are acceptable if they contain all of the above information and DO NOT indicate that insurance is pending. If the receipt is handwritten, it must include the service provider's signature.