Reimbursement Form

OneExchange
from Towers Watson

Mail: P.O. Box 981156, El Paso, TX 79998-1156 Fax: 1-844-930-0236

① Former Employer Name | Total Pages

Account Holder Name – Last | First | Middle

Social Security Number ___ - ___ - ____ Zip Code _____

②

Date of Service MM/DD/YYYY	Type of Coverage	Covered Participant Name	Relationship e.g., self	Amount Requested
01/01/2016	*Medical*	*John Doe*	*Spouse*	*$XXX.XX*
			Total Amount Requested	

③ By signing below, I certify that the information provided on this reimbursement form is correct and that the expenses for which I am requesting or for which I am providing validation: were incurred for expenses for the covered participant while eligible 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 Qualification item as you complete them.

☑ **Does your document(s) include these items?**

- ☐ Covered Participant Name (e.g., John Doe)
- ☐ Provider Name (e.g., AARP)
- ☐ Date of Service (e.g., 01/01/2016)
- ☐ Description of Coverage (e.g., Medigap)
- ☐ Proof of Amount Requested

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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 Information: Complete this section to indicate the Date of Service; Type of Coverage (e.g., Medical); Covered Participant Name and Relationship to the account holder; and Amount Requested, which should be the entire expense you incurred/paid.

③ Certification Requirements: Carefully read the certification requirements before signing.

④ Expense Documentation

Premium Reimbursement Documentation:

To file a request for a health premium (e.g., medical), you must provide supporting document(s) 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 Benefit Payment, please include the "Benefit Award Letter" issued by the Social Security Administration.

Requests for future premiums can be submitted with this form as long as the future premiums have been paid.

Medicare Part B Premiums must be submitted each month with the use of this form.

Out of Pocket Reimbursement Documentation:

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 (e.g., hospital, doctor, pharmacy) to qualify for the reimbursement.

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.

Documents and Reimbursement Submission:

Reimbursements cannot be processed without the required information or documents. If you have lost a document, contact your doctor, hospital, pharmacy, or health insurance carrier to request a copy.

Reimbursement requests can be submitted online, by fax, or by mail.

Once your request and receipts have been approved, you will receive payment within fourteen (14) days. If you have elected direct deposit, payment will be issued within three (3) days of the claim approval.