Total Financial Group

Total Financial Group is a superior organization with one common goal;
To create a portfolio for you that provides ultimate protection while maximizing your tax savings

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY

Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible incomplete forms.

Patient's Full Name: D.O.B S.S. #

Mailing Address

I, the undersigned, authorize the following provider/agency

to release/exchange my information to THE TOTAL FINANCIAL GROUP for the purpose of Treatment and Claims/Explanation of Benefits.

I understand that my records are protected under Federal (42 CFR part 2) Health Insurance Portal and Accountability Act of 1996 and State Confidentiality Regulations. This authorization is valid for release of information to the above named agency. This authorization shall be valid for a period of one year from the date signed unless revoked in writing by the undersigned or authorized representative. File copy is considered equivalent to the original. I further acknowledge that the information released was fully explained to me and this consent is given of my own free will.

FRAUD STATEMENT—Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I attest that the information given on this form is accurate and true to my knowledge, and that I will refund immediately any monies paid in error by the insurance carrier, as a result of misrepresented information on this form.

Patient Signature: _____ **Date:**

Parent/Guardian Signature _____ **Date:**

Primary Insurance

Grp # ID#

Phone Number

Insured's Name

D.O.B. SS #

Secondary Insurance

Grp # ID #

Phone Number

Insured's Name

D.O.B. SS#

Agency Providing Service **Phone Number**

Address

Total Financial Group, LLC

Creating the TOTAL benefit portfolio piece by piece

Classic 105 Medical Claim Reimbursement Form

- **Fax** completed forms to: 985-624-6840
- **Mail** completed form to:

Total Financial Group
Attn: claims
1427 West Causeway Approach Suite A
Mandeville, LA 70471

- **E-Mail** claim form to: claims@ttfg.org
- **Claims must be submitted within 60 days of date of service. If you need to submit the claim without your EOB from the insurance company to adhere to the 60 day limit, please furnish the EOB to complete the claim as soon as you can.**

1. Participant Information and Signature

By submitting this claim form, I (participant below) request reimbursement from the Classic 105 defined benefit as listed below. I agree to the terms and conditions stated below; I certify and warrant that these are eligible unreimbursed medical expenses that I have incurred.

Participant Name (please print):
Social Security Number:
Participant Address:
Employer Name:
Phone:
How may we contact you during the day? E-Mail:
Phone:
Participant Signature: **Date:**

2. Unreimbursed Medical Expenses

Patient Name	Provider Name and Phone Number	Description of Service	Date of Service	Cost of services provided

3. Terms and Conditions

I (above-named participant) understand and agree that:

- **These expenses are not reimbursements from any other health plan, insurance, or other source and will not be used to claim any federal income tax deduction or credit.**
- **The Unreimbursed Medical expenses listed above would be deductible medical expenses under Internal Revenue Code 213(d) and are allowed under Prop. Treas. Reg 1.125-2.**
- **I am responsible for any inappropriate use or disclosure of my personal information that occurs due to my selected method of transmittal of this information (e.g., fax, e-mail, or any other media)**
- **I authorize the Plan and its service provider (TTFG), their respective agents, employees, subcontractors, and assigns to use and/or disclose the information provided above as they reasonable deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan administration purposes, such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation.**
- **I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purpose defined above.**
- **This authorization does not in any way limit any right that TTFG, their respective agents, employees, subcontractors, and/or any assigns may have under applicable state of federal law or regulation.**

Helpful Tips for Completing your Classic 105 Medical Reimbursement Claim

1. Complete, **sign** and **date** the form. Failure to complete **all** areas can result in a delay in processing and claim reimbursement.
2. Attach a legible receipt, EOB(explanation of benefits)and claim number from the service provider
   - A description of the service or a list of supplies furnished
   - The charge(s) for each service.
   - The date(s) of service.
   - The name of person(s) receiving service.

   NOTE: Balance due statements and credit card receipts are not valid receipts unless they indicate all of the required information listed above. Never send in receipts without an accompanying claim form.
3. If you carry group or individual insurance, submit expenses to the insurance carrier first. Attach the Explanation of Benefits to document any reimbursement or credit to your deductible and coinsurance amounts.
4. Claims for reimbursement are from plan year to plan year, not calendar year. Check with your employer for the plan year start date.
5. Checks will not be written for less than $15. Requests for less than $15 will be applied to future requests.
6. Claims are reimbursed at 75% of claimed expense according to the schedule of benefits.
7. **Do not** submit an **Unreimbursed Medical** claim until after services are rendered.
8. If you receive services out of your insurance carriers network and the doctor or facility does not file the claim with your insurance carrier leaving you without an EOB, have the doctor or facility note the claim number on your receipt that correlates with the claim in their system. Only then may you file a claim without an EOB, but you must submit the receipt with the claim number along with the claim form to receive your reimbursement.
9. **Claims must be submitted within 60 days of date of service. If you need to submit the claim without your EOB from the insurance company to adhere to the 60 day limit, please furnish the EOB to complete the claim as soon as you can.**

Submitting Your Completed Form to TTFG

- **Fax** completed forms to: 985-624-6840
- **Mail** completed form to:
  Total Financial Group
  Attn: claims
  1427 West Causeway Approach Suite A
  Mandeville, LA 70471
- **E-Mail** claim form to: claims@ttfg.org

Note: Use discretion when faxing or emailing your personal medical information. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to TTFG.

For Customer Service call: 888-935-4555 or 985-624-2993

General IRS Guidelines

To qualify for reimbursement from the Classic 105 Plan, expenses must be incurred during the plan year for which you are requesting reimbursement.

1. **Unreimbursed Medical Account:** Used for medical expenses for you and your family (if utilizing the family option) that are not covered by any other health or insurance plan.

   Items covered must be for medical care as defined in section 213(d) of the IRS Code and allowed by the plan and may include but not limited to:

- Major medical copayments and deductibles (excluding insurance premiums of any kind)
- Certain medical (excluding cosmetic procedures).
- Please refer to the schedule of benefits for further qualified reimbursements

Total Financial Group will provide the process procedures to their employer through the plan documents.

The Total Financial Group
1427 West Causeway Approach Suite A
Mandeville, LA 70471