How to fill out your Health Reimbursement Account and Spending Account reimbursement claim form

Spending Account Administration, P.O. Box 14167, Lexington, KY 40512-4167, Fax: 1-800-905-1851

QUESTIONS? CALL HUMANA'S SPENDING ACCOUNT ADMINISTRATION AT 1-800-604-6228 – KYHEALTHPLAN.HUMANA.COM

Use this form only to **request reimbursement for healthcare expenses from your spending account**. Do not use this form to verify a HumanaAccess℠ Visa card swipe. For card swipe verification, please go to your *My*Humana page through **Humana.com**, input your name and password, click on "Claims and Spending," then click on "Expense Requiring Verification." Scroll down to your claim under "Verify or Repay" and follow the instructions.

Claim Submission:

Please fax one claim form, and the documents that support it, at a time. If you have other claim forms and supporting documents, please send them in a separate fax with a separate cover sheet. Please do not submit expenses for multiple plan years on the same form and do not use a highlighter on receipts or any part of the form.

Fax Submission - To help us process your claim payment quickly, please, fax the completed and signed reimbursement claim form, along with all documentation to **fax number 1-800-905-1851**.

Mail Submission - Please mail the completed and signed reimbursement claim form along with all supporting documentation to: Humana Spending Account Administration, P.O. Box 14167, Lexington, KY 40512-4167.

Please read these instructions before completing the information requested on the Spending Account reimbursement claim form. You must provide all necessary information or your claim may be denied.

Part I – Employee Information: Complete all areas of "Employee Information." Please print your information as clearly as possible.

Part II – Reimbursement Request: Check or complete the appropriate boxes. All healthcare expenses should first be filed under your employer's healthcare plan, or any other coverage you may have, before you request reimbursement from your Spending Account.

This form is to be used only to request reimbursement for:

- Allowable expenses that are not fully paid or reimbursed by any other benefit plans (e.g. co-pays, coinsurance, out of pocket). Please attach a copy of the plan's Explanation of Benefits (EOB) as documentation.
- Allowable expenses **not** covered by any other benefit plans. Please attach itemized bills or receipts that show the name and address of the provider who performed the service.

Explanation of Benefits statement (EOB): This is the statement you receive each time you or a healthcare provider submits medical, dental, or vision claims for payment to your plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. If you are covered under a HMO/DMO indicate "Co-payment" on Part II under " Claim Type-Other" and include itemized receipt(s).

Supporting Documentation – Healthcare Expenses

In addition to filling out this form, you must attach acceptable documentation. **Some plans require an EOB from your insurance carrier. If this expense was not covered by your insurance carrier, we will accept an itemized receipt. If you have an EOB for this expense, you must send it to us with this form, or your claim may be denied.**

For expenses not covered by your (or your dependent's) medical, dental, or vision plans, reimbursement requests will not be processed without acceptable documentation.

Cancelled checks and credit card receipts are not acceptable documentation. Acceptable documentation includes itemized receipts containing the following information:

- Type of service or product provided
- Date expense was incurred
- Name of employee or dependent for whom the service/product was provided
- Person or organization providing the service/product
- Amount of expense

Part III - Dependent Care Expenses: Check or complete the appropriate boxes.

Services provided by a childcare or elder care center must comply with all state and local laws to be eligible for reimbursement.

The following rules apply to dependent care expenses:

- The claimed expenses must be for the care of a child under age 13 or other dependents that are physically or mentally incapable of caring for self. These expenses must be incurred so that you (and your spouse, if married), can work, or your spouse can attend school full-time.
- Provider of services cannot be under the age of 19 and claimed as a dependent on your taxes.
- Dependent Care expenses will not be reimbursed until the end-date of service has passed.

The annual amount of dependent care claims cannot exceed:

- Your annual contribution amount up to $5,000 if you are single or married filing joint tax returns; $2,500 if you are married filing separate tax returns.
- Your annual salary or your spouse's annual salary, if less than $5,000.

Supporting Documentation – Dependent Care Expenses

- For allowable dependent care expenses, attach a copy of the receipt with dates of service, or have the provider complete and sign Part III "Dependent Care Expenses."

Part IV – Employee Certification for Reimbursement: Please read, sign and date.

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Part I: Employee Information (Please Print)

Employee Name (Last/First/MI)	Date of Birth	Member ID or Social Security Number
Employee e-mail Address (to receive your Spending Account correspondence via e-mail, please complete)		**Daytime Telephone #**

Part II: Reimbursement Request

Claim Type Combine all of the same type(s) of expenses on the same line.	**Dates of Service**		**What type of documentation is included for this expense? (check one or both)**		**Total Amount Requested**
	Beginning Date	**Ending Date**	***Explanation of Benefits (EOB)**	**Itemized receipt**	
Preventive Care					
Medical					
Vision					
Prescription					
Over-the-Counter Medication (OTC)					
Dental					
Durable Medical Equipment					
Other					
				Total Amount Requested:	

***Some plans require an EOB from your insurance carrier in order to be reimbursed from your Spending Account. If this expense was not covered by your insurance, we will accept an itemized receipt.**

Part III: Dependent Care Expenses

	Dependent's Full Name	**Date of Birth**	**Dates of Service**		**Amount Requested**	**Adult**	**Disabled**	**Daycare**
			Beginning Date	**Ending Date**				
1								
2								
3								
				Total Amount Requested:				

Provider Tax ID: (Optional)		**Provider Name:**

I provided adult/childcare services to the above individual(s) for the amounts and dates that are listed above:

Provider Signature: X_____ **Date:** X_____

Part IV: Employee Certification for Reimbursement

I hereby certify that:

- The above information is correct;
- I have not received and will not seek reimbursement for these expenses from any other plan, including through the use of my HumanaAccess℠ Visa, and these expenses are not eligible for reimbursement under any other plan.

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

I allow Humana, or its representative, to validate the supporting documentation I have provided (attached to this document) with doctors, hospitals, medical service providers, pharmacists, employers, and other agencies or organizations (including other insurers) to prove that these expenses are allowed under this plan and IRS guidelines.

Employee Signature: X_____ **Date:** X_____

TO EXPEDITE CLAIM PAYMENT, PLEASE FILL OUT THIS CLAIM FORM COMPLETELY AND PROVIDE SUPPORTING DOCUMENTATION.
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