BOON-CHAPMAN

Automatic Medical Reimbursement Authorization

INSTRUCTIONS:

1. **Complete the information below.**
   Return the completed, signed form to the Risk Management Department
   501 North Thompson, Suite #202
   Conroe, TX 77301
   ATTN: Virginia Little
2. **Or fax the completed form to the Risk Management Department**
   H.I.P.A.A. COMPLIANT FAX: 936-538-8169

Employer Name: **MONTGOMERY COUNTY, TEXAS Group # 248**

Participant Name: _____ SS#: _____

Participant Address: _____

City: _____ State: _____ Zip: _____

☐ I **elect** to have automatic reimbursement for my Medical Reimbursement Account for the _____Plan Year

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AT THE REQUEST OF THE INDIVIDUAL TO THE MEDICAL REIMBURSEMENT ACCOUNT ADMINISTRATOR

I request and authorize the health plan, its business associates and relevant medical providers to release protected health information to the Section 125 Medical Reimbursement Account Benefit Administrator, BOON-CHAPMAN INC.

The purpose of the release of information concerning deductibles, co-pays and medical expenses that I or my dependents may incur and that may qualify for reimbursement is to facilitate payment of eligible expenses from my Section 125, Medical Reimbursement Account.

This authorization shall continue while I am eligible under the health plan or until I revoke the authorization in writing by delivering a copy of the revocation to the privacy officer. I understand that if I revoke this authorization that the effect of such revocation will only be for the future and will not affect disclosures or uses of my protected health information that have occurred in reliance on this authorization. I acknowledge that by authorizing release of information to the above stated individual(s) that the health plan cannot control re-disclosure of the information. I also acknowledge that the health plan based on this authorization disclose without further authorization requested protected health information for the purposes of treatment, payment, health care operations and any other above listed purpose. I also acknowledge that I have received a copy of this authorization.

This option allows automatic reimbursement for items paid under your health, dental and/or vision claims administered by Boon-Chapman. Any qualified medical reimbursement claims would be extracted from the claims payments system and imported into the Medical Reimbursement Account Claims payment system. This allows for automatic reimbursement for any deductibles, co pays and/or co insurance without you having to file a separate claim for qualified medical reimbursements.

If this option is selected, the participant must understand expenses should not be manually filed for health that Boon-Chapman will process since automatic reimbursement will take place.

☐ I **do not elect** to have automatic reimbursement for my Medical Reimbursement Account.

_____ _____

Participant Signature Date Signed