MERITAIN HEALTH

Mail completed form to:	**Meritain Health** **18444 N. 25th Avenue,** **Suite 410** **Phoenix, Arizona 85023**
Fax to:	**716.541.6664**

REIMBURSEMENT REQUEST FORM

Employer Name: _____

Employee Name: _____ **SS# or ID#:** _____

Address: _____ **Telephone #:** _____

City: _____ **State:** _____ **Zip:** _____ **Is this a change of address?** ❑ Y or ❑ N

Select account from which you are requesting reimbursement, and fill out all requested information completely.
For further instructions, see Guidelines for Reimbursement *on back of this form.*

❑ Health FSA *OR* ❑ Health Reimbursement Arrangement (HRA)

Date of Service	Name of Provider (Ex: physician, hospital, dentist, pharmacy)	Type of Service (Ex. copay, Rx, ortho)	Name of Patient	Amount of Expense	Was this service covered by any insurance plan?
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
Total amount requested from your **Health FSA or HRA:**				$	

If more space is needed, list additional requests on a separate page. Please include all requests in the total.
A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.

❑ Dependent Care Assistance Plan (DCAP)

Name of Day Care Provider	Dates of Service		Dependent's Name	Date of Birth	Amount of Expense
	From	To			
					$
					$
					$
Total amount requested from your **DCAP**:					$

Provider Signature: _____ **Provider SSN# or Tax ID:** _____

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature: _____ **Date:** _____

Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, sign and date form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

Health Flexible Spending Account and Health Reimbursement Account

- Attach a copy of the Explanation of Benefits (EOB) for each submission. All claims **MUST** be submitted to your insurance company prior to request for reimbursement. **Estimates for services that have not yet been incurred cannot be accepted.**

  OR

  Submit a paid receipt for your co-payments. **Credit card receipts, canceled checks, or cash register receipts cannot be accepted for copayments. Itemized cash register receipts are acceptable for over-the-counter (OTC) items/supplies that do not contain a medicine or drug. If the OTC item <u>does</u> contain a medicine or drug, you will need to submit a cash register receipt as well as a doctor's prescription.**

  OR

  If you do not have insurance coverage, submit an itemized statement from the provider showing the provider's name and address, patient name, date and description of service and amount charged. Additionally, prescription expenses must include the drug name or number. **Balance forward or paid on account statements cannot be accepted.**

- Orthodontic reimbursement: For first request, submit a copy of the Service Agreement or contract itemizing the treatment period, down payment, monthly payment, banding date and amount covered by insurance, if any. For subsequent claims, submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement.

Dependent Care Reimbursement Account

- Expenses submitted must have been incurred for the care of a "qualifying individual" for the purpose to be gainfully employed.
- A qualifying individual is (i) a dependent of yours under age 13, (ii) a dependent of yours (or your spouse) who is incapable of caring for himself/herself.

Medical and Dental Expenses Generally Eligible for Reimbursement

(Source: IRS Tax Publication 502)

You *Should* Claim

- Fees for health services or supplies provided by physicians, surgeons, dentists, ophthalmologist, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, or Christian Science practitioners
- Acupuncture
- Fees for hospital, ambulance, laboratory, surgical, obstetrical, diagnostic, dental and X-ray services
- Costs incurred, including room and board, during treatment for alcohol or drug addiction at a hospital or treatment center
- Special equipment, such as wheelchairs, special handicapped automotive controls, and special phone equipment for the deaf
- Special items, such as dentures, contact lenses, eyeglasses, hearing aids, crutches, artificial limbs and guide dogs for the vision or hearing impaired
- Transportation for needed medical therapy
- Nursing services
- Rehabilitation expenses

You Should *NOT* Claim

- Any items which will be paid for by insurance or for which you are reimbursed by insurance or any other health plan
- Bottled water
- Health club dues
- Any illegal operation or treatment
- Programs to control weight (unless the program is undertaken at a physician's direction to treat an existing illness, including obesity)
- Elective cosmetic surgery
- Medical insurance premiums paid outside of your company by you or your spouse at his or her place of employment
- Nursing care for a normal, healthy baby
- Maternity clothes
- Burial expenses