How to Submit a Manual Claim

Manual claims should be submitted through your Choice Strategies online account. Submitting claims online is easy and allows you to receive your reimbursement faster. For instructions on how to submit claims online, we've created this brief step-by-step presentation:

https://www.brainshark.com/ccc/vu?pi=zFXzOKGD5z23dmz0

If you can't submit claims online, you may also complete the following Claim Form. This form should be completed and sent back to Choice Strategies along with your supporting documentation.

What kind of supporting documentation should I send?

- ***Medical Expenses***: Explanation Benefits (EOB) or Detailed Provider Statement
- ***Prescription***: Itemized Receipt or EOB
- ***OTC***: Itemized Register Receipt
- ***Dental***: Provider Statement or EOB
- ***Vision***: Provider Statement or EOB
- **Premium Reimbursement**: The bill you receive from your health insurance carrier

For more information, visit the FAQ pages of our website, www.choice-strategies.com.

Where do I send my claim?

- **Fax:** 802-244-2020
- **Email:** Claims@choice-strategies.com

Tips for Faster Reimbursement:

- ***Submit Claims Online:*** Log onto your account at www.choice-strategies.com.
- ***Provide Your Direct Deposit Information:*** Enter your direct deposit information through your online account. This eliminates mailing time for checks and puts your money in your bank account faster.

Have Questions? Contact Member Services!

memberservices@choice-strategies.com
Phone: 888-278-2555 Ext. # 2
Fax: 802-244-2020

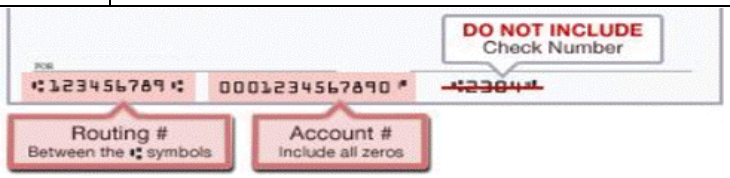
CHOICE™ STRATEGIES

* Required Field

* Demographic Information		
Employee Last Name:	**Employee First Name:**	**MI**
Social Security Number:	**Employee Mailing Address (complete only if there is a change):**	
City:	**State:**	**Zip:**
Employer Name:	**Email (complete only if there is a change):**	

DIRECT DEPOSIT - Stored for future reimbursement		
☐ Checking ☐ Savings	**Routing Number (9 Digits):**	**Account Number:**

IMPORTANT: **Do not include amounts eligible for payment under any other health plan. Reimbursement for the total listed will be issued to the primary account holder only. Please note that if a check or direct deposit must be reissued due to employee error, a $15.00 fee will apply.**



Expenses to be Reimbursed					
* Account Type	* Date of Service:	* Amount:	* Pay Me/ Pay My Provider:	Provider Name:	If Pay My Provider: Provider Address, City, State and Zip If Left Blank: We Will Reimburse You
1		$	☐ Pay Me ☐ Pay My Provider		
2		$	☐ Pay Me ☐ Pay My Provider		
3		$	☐ Pay Me ☐ Pay My Provider		
4		$	☐ Pay Me ☐ Pay My Provider		
5		$	☐ Pay Me ☐ Pay My Provider		

Initial and Submit to: claims@choice-strategies.com or Fax 1-802-244-2020

Initial: _____ **Date:** _____