IBEW-NECA Southwestern Health and Benefit Fund

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

Instructions: Please print or type and complete all items under Personal Information. In order to receive reimbursement, you must submit an Explanation of Benefits Statement (if applicable) from this Health Plan, or an itemized statement that includes the provider name, patient name, date of service, and description of service for each health care claim. Cancelled checks, credit card slips, or statements showing only a balance due on your account are not acceptable. Please sign and date this form and attach any original corresponding receipts or other appropriate documentation. For further inquiries call 1-800-527-0320.

Return Completed form and all Documentation to:

IBEW-NECA Southwestern Health and Benefit Fund
Health Reimbursement Arrangement
P.O. Box 819015
Dallas, Texas 75381-6308

PERSONAL INFORMATION

Name: Last _____ First _____ M.I. _____

SOCIAL SECURITY # ☐☐☐ ☐☐ ☐☐☐☐ HOME TELEPHONE ☐☐☐ ☐☐☐ ☐☐☐☐

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

NON-REIMBURSED MEDICAL EXPENSES

(Qualifying Medical Expenses for you or your Dependents)

DATE EXPENSE INCURRED (MM/DD/YY)	NAME OF SERVICE PROVIDER (CLINIC, PHARMACY, DOCTOR, STORE, ETC.)	DESCRIPTION OF EXPENSE	PATIENT NAME	OUT–OF POCKET PAID BY YOU	FOR INTERNAL USE ONLY
				$	
				$	
				$	
				$	
				$	
			Total:	$	

Service must be totally rendered and completed. Total claim amount must equal or exceed $100 before you submit your claim for reimbursement.

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Healthcare Reimbursement Arrangement Account. I am claiming reimbursement only for eligible expenses incurred by myself, my spouse and/or covered dependents, and certify that these expenses have not been reimbursed under this Plan or by any other source and that they will not be reimbursed by any other source or insurance. I hereby authorize my HRA Account to be reduced by the amount(s) shown above.

Participant's Signature _____ Date _____

IMPORTANT HRA CLAIM SUBMISSION INFORMATION

Definition of "Incurred"

The term "incurred" refers to the date you or your eligible dependent is provided with the care that gives rise to the medical, dental, vision, prescription, or other qualifying expense. This date could be different than the date you are billed or pay for the expense. Per IRS regulations, the date the service is incurred determines the plan year in which it is considered for reimbursement.

Additional Employee Certification

I certify the expenses for which I am claiming:

- Were incurred by my eligible dependents or me (spouse is considered a dependent) during a plan year in which I and/or my dependent(s) were covered under the Plan.
- Will not be claimed as a deduction or credit on any personal income tax return.
- Are eligible according to the terms of the Plan. If I've received reimbursement for expenses later found ineligible, I will be responsible for any penalties arising from the ineligible expense

Helpful Hints on How to Successfully File a Claim

- ☐ Documentation must clearly list the date the service was incurred, provider name, description of expense, patient's name and out of pocket amount paid by you.
- ☐ If the expense incurred is reimbursable by the Plan or an insurance company, you must submit the expense to the Plan or insurance company first. You can then use the Explanation of Benefits (EOB) received from the Plan or insurance company as your expense documentation. **The EOB you receive from the Plan or your insurance company is the best source of expense documentation for use in submitting your claims.**
- ☐ Cancelled checks, 'balance forward' statements, 'previous balance' statements, 'paid on account' statements or receipts, charge card receipts, or charge card statements are not acceptable forms of expense documentation according to the IRS as they do not clearly indicate the date or type of service.
- ☐ For prescription expenses, submit the prescription receipt you received with the medication purchased showing the patient name medication name, the date the prescription was filled, and the amount owed for the medication. **Cash register receipts or charge slips for prescription purchases cannot be accepted, as they do not indicate the medication name or patient.**
- ☐ Claims incurred during the plan year in the aggregate of $100 or more can be submitted at any time during the plan year or during the grace period (referred to as the "timely filing period"). **Claims received after the timely filing period has expired for the plan year in which they were incurred cannot be considered for reimbursement.**
- ☐ Expenses must be incurred prior to being considered for reimbursement. If the expense has not been incurred, your claim will be returned to you.
- ☐ Send ORIGINAL documents and retain copies for your files.

Some Expenses that are <u>NOT</u> Eligible for Reimbursement*

- Dietary supplements or vitamins for general well-being
- Over-the-counter medication if specifically excluded by your plan
- Teeth bleaching or whitening
- Athletic or health club memberships, <u>except where prescribed by a physician</u>
- Supplements from a chiropractor, acupuncturist, holistic healer, etc
- Cosmetic surgery
- Weight loss programs for general well-being

* See Summary Plan Description for complete list

Other Definitions

Plan Year - The plan year is defined as January 1 through December 31.

Name of Service Provider / Expense Description - Doctor name, store name, dentist, hospital, etc. along with the service performed (example, 'Dr Jones / Office Visit' or CVS Pharmacy / Rx).

Net Amount - The amount of the expense you are responsible for paying.

Timely Filing Period – The period within the twelve months after the date charges were incurred.