REQUESTING REIMBURSEMENT FROM YOUR HEALTH CARE ACCOUNT

(Do not fax or mail this instruction page)

This form is used to request reimbursement for health care expenses only. All health care expenses should be first submitted to your health care plan or any other health care coverage that you may have. This form should only be used to request reimbursement for:

- Allowable expenses covered but not fully reimbursed by any benefit plans (e.g., copayments).
- Allowable expenses NOT covered by any benefit plans (e.g., over-the-counter medicines).

Option 1: ***Go Paperless!*** You won't need to complete paper forms anymore.
Submit claims online at www.acclarisonline.com.

Option 2: Submit your claim using this form.

Step 1: Complete the form

- *Please print in capital letters, with the letters centered in the boxes as shown:*

A	B	C	D		1	2	3	4

- *Complete a separate line for each individual expense.*
- *Use page 3 if you exceed the number of lines available on page 2.*

Step 2: Attach Supporting Documentation

- *See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable by the IRS.*
- *Do not send original receipts or supporting documentation.*
- *Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.*

Step 3: Certify

- *Read the Certification and then sign and date the form.*

Step 4: Submit

- **FAX** *the form and supporting documentation to* **1.813.830.7900.**
- *Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.*
- *Do not fax this instruction page or your own fax cover-sheet.*
- *Alternatively, you may also mail your claims to:*
  Acclaris Reimbursement Center
  PO Box 25171
  Lehigh Valley, PA 18002-5171
  To expedite processing, please send only one claim and supporting documentation per envelope. Sending multiple claim forms in the same envelope may delay processing.

Remember

- *Keep a copy of the form and all original receipts for your records.*

Type of Supporting Documentation

- Copy of itemized receipts from your pharmacy or medical/dental/vision provider.
- Copy of Explanation of Benefits (EOB) from your insurance company or health care provider.
- Must show:
  - Date(s) of service(s) or purchase.
  - Type of service or name of product.
  - Amount (paid by you).
  - Name of person or organization providing the service or product.
- Cancelled checks or payment statements are not considered acceptable evidence.
- Receipts for **over-the-counter (OTC) medications** must show the purchase date and the name of the medicine or drug. Please circle the expense and medication or drug name on your receipt. An EOB form is not required for eligible OTC medications.

Please Do

- For multiple expenses on one receipt for the same expense code, use one line to show a total of such expenses (e.g., several over-the-counter items, multiple prescription copays listed on one receipt).
- For expenses that belong to different expense codes or are on different receipts, use one line per expense.
- Use additional copies of Page 3 if your expenses exceed the number of lines available on Page 2 and Page 3.
- Be sure to print legibly and use capital letters.

Please Do Not

- Fill out the form using red or blue ink.
- Highlight receipts or any part of the form.
- Send original receipts.
- Staple copied receipts to the form.
- Write outside the boxes provided.
- Submit the same claim more than once.
- Fax or mail this Instruction Page.

List of Expense Codes - Sections 2 and 5 of the form need to specify the type of expense using one of the following:

Medical
101 = Ambulance
102 = Co-Insurance
103 = Deductible
104 = Doctor
105 = Equipment
106 = Hospital
107 = Laboratory
108 = Pharmacy Prescription
109 = Related Travel
110 = Therapy

Medical - OTC
111 = Over-the-Counter Medication

Medical - Preventative
201 = Immunization
202 = Physicals
203 = Screening
204 = Smoking Cessation
205 = Weight Loss

Dental
301 = Equipment
302 = Examination
303 = Orthodontia
304 = Over-the-Counter Medication
305 = Pharmacy Prescription
306 = Treatment

Vision
401 = Equipment
402 = Examination
403 = Over-the-Counter Medication
404 = Pharmacy Prescription
405 = Treatment

For a list of eligible expenses, go to www.acclarisonline.com

Health Care Claim Form

FAX TO: 1.813.830.7900
or Mail to: Acclaris Reimbursement Center, PO Box 25171
Lehigh Valley, PA 18002-5171

Acclaris® the clear choice

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SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)

PARTICIPANT ID or SSN (IF SSN, NO DASHES)

EMPLOYER or GROUP NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

PARTICIPANT EMAIL

DAYTIME PHONE # (AREA CODE FIRST - NO DASHES)

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS)

EXPENSE 1
EXPENSE CODE

DATES OF SERVICE
FROM (MMDDYY)

TO (MMDDYY)

AMOUNT
$.

PROVIDER NAME

SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 2
EXPENSE CODE

DATES OF SERVICE
FROM (MMDDYY)

TO (MMDDYY)

AMOUNT
$.

PROVIDER NAME

SERVICE PROVIDED TO (NAME & RELATIONSHIP)

SECTION 3: SELF CERTIFICATION

I certify that the expenses for reimbursement requested above were incurred by me (and/or my spouse and/or eligible dependents, as defined in tax code Section 152) and that the description of these expenses are accurate and meet the guidelines specified under the plan as well as Internal Revenue Code Sections 105 and 125, and supporting IRS Regulations. I certify that any over-the-counter medication or drug requested above was purchased for my (and/or my spouse and/or eligible dependents, as defined in tax code Section 152) medical care and were not purchased for general good health. I further declare that these expenses have not previously been reimbursed to me nor will I seek reimbursement from any other plan covering health benefits. I understand that claims must be filed by the claims filing deadline for the plan year.
I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information is guilty of a crime and may be liable for substantial civil penalties. I hold Acclaris, its affiliated companies, officers and employees harmless for payment of any ineligible expenses presented in such a manner.

EMPLOYEE SIGNATURE:* _____ DATE: _____

*Your signature is required in order to process your claim for reimbursement

DO NOT SEND ORIGINAL RECEIPTS

HFB1

Health Care Claim Form

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Lehigh Valley, PA 18002-5171

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SECTION 4: YOUR INFORMATION (ABBREVIATED) (Use only CAPITAL LETTERS)

PARTICIPANT ID or SSN (IF SSN, NO DASHES)

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

SECTION 5: YOUR EXPENSES

EXPENSE 3
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
TO (MMDDYY)
AMOUNT $.
PROVIDER NAME
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 4
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
TO (MMDDYY)
AMOUNT $.
PROVIDER NAME
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 5
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
TO (MMDDYY)
AMOUNT $.
PROVIDER NAME
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 6
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
TO (MMDDYY)
AMOUNT $.
PROVIDER NAME
SERVICE PROVIDED TO (NAME & RELATIONSHIP)

EXPENSE 7
EXPENSE CODE
DATES OF SERVICE FROM (MMDDYY)
TO (MMDDYY)
AMOUNT $.
PROVIDER NAME
SERVICE PROVIDED TO (NAME & RELATIONSHIP)