PAYFLEX®

Health Reimbursement Arrangement (HRA)/ Retiree Reimbursement Arrangement (RRA)Claim Form

ECHS category: PFHR

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
PO Box 14879
Lexington, KY 40512-4879
Toll-Free Fax: 1-888-238-3539
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1-888-678-8242 (TTY: 711)

To avoid a delay in claim processing, you need to sign, date and complete this form. You must also include supporting documentation.
Don't Forget: You can file claims online. You will find the instructions in the Frequently Asked Questions (FAQs) document mailed to you by PayFlex when you became eligible for your RRA. The FAQs are also available on the PayFlex website.

Account Holder Full Name *(Last Name, First, MI)*	
Social Security Number (Last four digits only) XXX-XX-__ __ __ __	**Account Holder Date of Birth** *(mm/dd/yyyy)*
Address *(Street, City, State, ZIP Code) If you have an address change, please notify your benefits center. For security purposes, we can only accept an address change from them.*	
Employer Name	

Health Care Expenses: Fill out this section if you are requesting reimbursement for a Medical, Dental or Prescription expense, as allowed by your plan:

Patient Name	Type of Service (deductible, dental, medical, orthodontia, OTC, RX, vision)	Beginning Date of Service (not payment date) MM/DD/YYYY	Ending Date of Service (not payment date) MM/DD/YYYY	Amount Requested
				$
				$
				$
				$
				$
****If more lines are needed, please complete another form.** Attach the supporting documentation for each claim.			**Total**	$ 0

Insurance Premium Expenses

If your Medicare Part B Premium is deducted from your Social Security check: For your first request for reimbursement, include a copy of the statement you received that shows your premium is being deducted from your Social Security check. We will keep this on file for the remainder of the calendar year. After that first request, all you'll need to do is resend this claim form monthly to receive your reimbursement.

For lost documents, you can contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

If you pay other eligible premiums for coverage like Medicare Supplement Insurance, Prescription Drug, Dental or Vision Insurance directly to the insurance company: Each month and as allowed by your plan send a copy of the statement from the insurance company showing your premiums, the covered individual's name, type of coverage, dates of coverage and proof of payment along with this claim form**.**

Note: Premiums that you pay pre-tax are not eligible expenses.

Insurance Premium Expenses: If you are requesting Premium Reimbursement, fill out this section:

Name of Covered Individual	Type of Premium (Medicare Part B, Medicare Part C, Medicare Part D (Prescription Drug), Dental, Medigap, etc.)	Did you already submit your Annual Social Security Administration Letter? If No, include a copy along with this claim form	Beginning Date of Service MM/DD/YYYY	Ending Date of Service MM/DD/YYYY	Amount Requested
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
****If more lines are needed, please complete another form.** Attach the supporting documentation for each claim.				**Total**	$ 0

For Health Reimbursement Arrangement (HRA) members: I understand that an Internal Revenue Service (IRS) rule only lets me use my HRA for eligible individuals if they're covered by a compliant group health plan*. I certify that the patient noted on my claim (myself, spouse, or eligible dependent) is covered under my Employer's group health plan or another compliant group health plan*. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions. *The group health plan must be compliant with the Affordable Care Act (ACA). It can't have annual or lifetime dollar limits on essential health benefits. And it can't exclude coverage because of pre-existing conditions.

I certify that my spouse, eligible dependent or I have incurred each expense on this form. These expenses are for eligible medical care. The expense is not for cosmetic purposes. I understand that "incurred" means that the service has been provided. It does not mean when I am billed, charged or pay for the medical care. I have not received reimbursement for these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed materials for the reimbursement account (HRA or RRA) and agree to all of the terms and conditions. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Account Holder Signature	**Date**
✍	

If you're mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return the documents we receive.

Helpful Hints for Completing this Form

STEP 1: Account Holder Information	• **Account Holder Full Name –** Enter your last name, first name and middle initial in the space • **Social Security Number** – Enter the last four digits of the account holder's Social Security Number • **Account Holder Birth Date –** Enter the two digit month, two digit day and four digit year (mm/dd/yyyy) of the account holder's birth date • **Address** – Enter the account holder's home address including ZIP code. If you have an address change, please notify your benefits center. For security purposes, we can only accept an address change from them. • **Employer Name –** Enter the name of your former employer
STEP 2: If you're requesting reimbursement for a medical, dental, prescription or other out-of-pocket medical expense, as allowed by your plan, complete the fields in the open lines and boxes in the Health Care Expenses box:	• **Patient Name –** Enter the name of the person who received the service. • **Type of Service –** Enter the type of service that was provided; for example, was it for prescription drugs, eye glasses, dental, other out-of-pocket costs not covered by insurance such as deductible, co-pay, co-insurance. . • **Beginning Date of Service –** Enter the month, day and year of the first day the service was provided. This is not the date of payment. For prescription drugs, the date of service is the date the prescription was filled or ordered. • **Ending Date of Service –** Enter the month, day and year of the last day the service was provided. • **Amount Requested –** Enter the amount you're requesting to be reimbursed. The requested amount needs to match the amount on your supporting documentation.
STEP 3: If you're requesting reimbursement for eligible insurance premiums, as allowed by your plan, complete the fields in the open lines and boxes in the Insurance Premium Expenses box**:** **NOTE:** If you've paid your premium in full for the calendar year, the Beginning Date of Service should be 01/01/20XX and the Ending Date of Service should be 12/31/20XX. If you've paid your premium by quarter, enter the appropriate beginning and ending dates for that quarter.	• **Name of Covered Individual –** Enter the name of the person who is covered by the health plan that the premium reimbursement is being requested. • **Type of Premium** – Enter the type of premium you want reimbursed; for example, Medicare Part B, Medicare Part C (Advantage), Medicare Part D (prescription drug), Medicare Supplement (Medigap), dental, vision. • **Annual Social Security Administration Letter –** If your Medicare premiums (Parts B, C or D) are deducted from your Social Security check and this is the first time you're requesting reimbursement of those premiums this calendar year, you need to send a copy of your Social Security Benefit Award Letter from the Social Security Administration. This document is sometimes called a "Proof of Income" letter or "Your New Benefit Amount" and is typically mailed in November the year before it becomes effective. If you're attaching this documentation for the first time, check "No". If you have already sent this documentation with a previous request for reimbursement, check "Yes". • **Beginning Date of Service –** Enter the month, day and year that reflects the beginning of the period that you made your premium payment. For example, if you made a premium payment for the month of January, the Beginning Date of Service will be 01/01/20XX. • **Ending Date of Service –** Enter the month, day and year that reflects the end of the period that you made your premium payment. For example, if you made a premium payment for the month of January, the Ending Date of Service will be 01/31/20XX. • **Amount Requested –** Enter the amount you're requesting to be reimbursed. If you paid your annual premium in full, put the annual amount here. The requested amount needs to match the amount on your supporting documentation.
STEP 4: Carefully read the certification section. Then sign and date the form.	
STEP 5: Mail or fax your completed form **and** supporting documentation to: **PayFlex Systems USA, Inc.** **PO Box 14879** **Lexington, KY 40512-4879** **Toll-Free Fax: 1-888-238-3539** **If you're mailing your claim, please keep a copy of this claim form and supporting documentation. PayFlex will not return these documents.**	• **For Medicare premiums deducted from your Social Security check**, include a copy of your Social Security Benefit Award Letter (or other Medicare statement that clearly indicates your Medicare Part B, Part C or Part D premium, as applicable) from the Social Security Administration. This document is sometimes called a "Proof of Income" letter or "Your New Benefit Amount" and is typically mailed in November the year before it becomes effective. • **For eligible insurance premiums other than Medicare**, your supporting documentation needs to include: – Covered individual's name (Example: John Doe) – Insurance carrier's name (Example: Aetna) – Dates of coverage (Example: 01/01/20XX – 12/31/20XX) – Type of coverage (Example: Medigap) – Premium amount (Example: $120.50/month) – Proof of payment, that includes any of these examples: o Bank statements showing the withdrawal or payment to "XYZ Insurance Company" has cleared o Insurance company statement showing payment in full for the coverage period o Ongoing monthly insurance company statements showing previous months premium payment o Cancelled check for premium payment to insurance company (copy of front of cancelled check) o Credit card statements showing payment to insurance company • **For health care expenses** – Once your insurance carrier has made its decision, you'll receive an Explanation of Benefits (EOB). Submit the EOB with this claim. If you do not have insurance coverage for the expense, you must include an itemized receipt or statement* from the provider. Your documentation needs to include: o Provider name and address o Patient name o Description or Type of service o Date of service (not date of payment) o Dollar amount charged for the expense ***NOTE:** If you don't include the itemized receipt or statement, your health care claim will not be processed. We cannot use a cancelled check, credit or debit card receipt, or billing statement that shows "previous balance", "balance forward", or "estimated, filed and pending insurance" as documentation.