HealthEquity | WageWorks

www.HeathEquity.com/WageWorks

HEALTHCARE ACCOUNT

*For employers offering an Integrated HRA**

Pay Me Back Claim Form Instructions

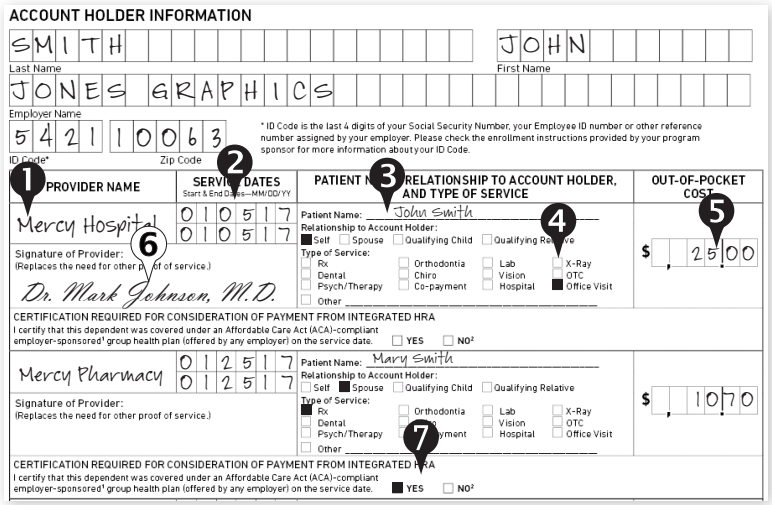
Claim Filing Options:

- **File claim online:** Log into your account at www.HeathEquity.com/WageWorks to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 877-353-9236 , **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information.
- Provide your employer name without abbreviation.
- Certify the patient has compliant group health plan coverage.
- Use your documentation to complete each section of the form, including the following:

① Provider Name
② Service Date(s)
③ Patient Name and Relationship to Account Holder
④ Type of Service
Patient Responsibility
⑥ Provider Signature is not required, but can replace need for other proof of service
⑦ Check box to indicate required coverage (if claim is to be considered for payment from Integrated HRA*)



*An Integrated Health Reimbursement Account (HRA) is an employer-funded medical reimbursement plan that is linked with an Affordable Care Act (ACA)-compliant employer-sponsored group health plan. Your participation in the group health plan is typically a condition of your coverage under the HRA.

To be considered for payment under an Integrated HRA, you will need to:

Provide the dependent's full Social Security number and date of birth.

- This information can be entered along with your claim on our website or mobile app.
- As of 1/19/17, you can enter this information independent of the claim on our website on the Profile > HRA Dependents page.
- For security reasons, we do not collect this information on this claim form.

Certify that the dependent was covered under an ACA-compliant employer-sponsored group health plan (yours, your spouse's, or their own) on the claim service date.

Tips For Claim Submission

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
  - A qualifying child is defined as a dependent child up to age 26 or any age if permanently disabled.
  - A qualifying relative is someone who who lives with you as a member of your household for the calendar year.
  - Qualifying children and relatives must not provide more than half of his/her own support.
- For information to claim orthodontia expenses, refer to the guide located at: https://www.wageworks.com/employees/support-center/important-forms.aspx.
- For a complete list of eligible expenses specific to your plan, log in to your account at www.HeathEquity.com/WageWorks and select "Eligible Expense" from the left side of the screen. Only submit claims for eligible expenses.
- A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. Cosmetic surgery or procedures, e.g., teeth whitening, are not eligible expenses unless deemed as medically necessary by a licensed physician. A letter of medical necessity form can be obtained at: https://www.wageworks.com/employees/support-center/important-forms.aspx.

Tip for Over-the-Counter Expenses

- A prescription is required for any over-the-counter expense listed as "Yes (Rx)" on the eligible expense list. As a result of the Health Care Reform Law, in addition to the required detailed receipt, an actual prescription written by a doctor (on a prescription pad or form) dated on or before the date the expense was incurred is required to verify that the over-the-counter medicine is prescribed for a known medical condition.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 6 required pieces of information needed to approve your expense, and are not acceptable for submission.
- Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.
- Your provider may sign the form confirming the date of services, charges and other service or product information in lieu of providing separate documentation or other proof of service.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log into your account at www.HeathEquity.com/WageWorks and select "Profile" in the upper right corner of the screen).

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Pay Me Back Claim Form

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at www.HeathEquity.com/WageWorks to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: **Fax:** 877-353-9236,
  US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging in to your account at www.HeathEquity.com/WageWorks.

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ACCOUNT HOLDER INFORMATION

Last Name

First Name

Employer Name

ID Code*

Zip Code

* ID Code is the last 4 digits of your Social Security Number, your Employee ID number or other reference number assigned by your employer. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

PROVIDER NAME	SERVICE DATES Start & End Dates—MM/DD/YY	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER, AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative Type of Service: ☐ Rx ☐ Orthodontia ☐ Lab ☐ X-Ray ☐ Dental ☐ Chiro ☐ Vision ☐ OTC ☐ Psych/Therapy ☐ Co-payment ☐ Hospital ☐ Office Visit ☐ Other _____	$
CERTIFICATION REQUIRED FOR CONSIDERATION OF PAYMENT FROM INTEGRATED HRA I certify that this dependent was covered under an Affordable Care Act (ACA)-compliant employer-sponsored[1] group health plan (offered by any employer) on the service date. ☐ YES ☐ NO[2]			
Signature of Provider: (Replaces the need for other proof of service.)		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Qualifying Child ☐ Qualifying Relative Type of Service: ☐ Rx ☐ Orthodontia ☐ Lab ☐ X-Ray ☐ Dental ☐ Chiro ☐ Vision ☐ OTC ☐ Psych/Therapy ☐ Co-payment ☐ Hospital ☐ Office Visit ☐ Other _____	$
CERTIFICATION REQUIRED FOR CONSIDERATION OF PAYMENT FROM INTEGRATED HRA I certify that this dependent was covered under an Affordable Care Act (ACA)-compliant employer-sponsored[1] group health plan (offered by any employer) on the service date. ☐ YES ☐ NO[2]			

More expenses? Please complete another form.

CLAIM FORM TOTAL: $

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the User Agreement at www.HeathEquity.com/WageWorks (available upon registration; enter username and password or click on LOG IN/REGISTER, Employee Registration.

[1] Any employer (yours, your spouse's, or the patient's)

[2] Select NO if you do not want to provide the SSN and DOB and/or if you do not want this claim considered for payment from the Integrated HRA.