HEALTHCARE ACCOUNT
For employers offering an Integrated HRA*
Pay Me Back Claim Form Instructions

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
  5. 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*)

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 lives with you as a member of your household for the calendar year.
  - Qualifying children and relatives must not provide more than half of their own support.
• For information to claim orthodontic 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.wageworks.com 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.

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.
• 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.wageworks.com and select “Profile” in the upper right corner of the screen).

*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:
• 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 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.
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- File claim online: Join the growing majority of participants who submit their claim online for faster service. Log in to your account at www.wageworks.com 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.wageworks.com.

*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.

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.

<table>
<thead>
<tr>
<th>PROVIDER NAME</th>
<th>SERVICE DATES Start &amp; End Dates—MM/DD/YY</th>
<th>PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER, AND TYPE OF SERVICE</th>
<th>OUT-OF-POCKET COST</th>
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<tr>
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<td>Relationship to Account Holder:</td>
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<td>Self Spouse Qualifying Child Qualifying Relative</td>
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<td>Type of Service: Rx Dental Psych/Therapy Co-payment</td>
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<td></td>
<td>Lab Chiro Vision X-Ray BTC Office Visit</td>
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<td>Other</td>
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</table>

Signature of Provider: (Replaces the need for other proof of service.)

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 group health plan (offered by any employer) on the service date. YES NO

Patient Name:
Relationship to Account Holder:
Self Spouse Qualifying Child Qualifying Relative
Type of Service:
Rx Dental Psych/Therapy Co-payment
Lab Chiro Vision X-Ray BTC Office Visit
Other

Signature of Provider: (Replaces the need for other proof of service.)

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Signature of Provider: (Replaces the need for other proof of service.)

More expenses? Please complete another form.

CLAIM FORM TOTAL: $