

How To File a Health Care Claim

To complete a Health Care reimbursement request (a claim), you must submit a *Health Care Claim Form* along with the receipts that clearly show an eligible expense was incurred. Here are the steps to follow:

1. Complete a *Health Care Claim Form*
2. Attach itemized documentation and, if required, your physician's statement of necessity
3. Fax us the Form and the documentation



The *Claim Form* must be completed entirely, dated and signed. The supporting receipts or billing statements must state the vendor name, vendor contact information, purchase date, a description of the expense(s) and the expense amount. An Explanation of Benefits (EOB) from medical plans can also be used as supporting documentation for your claim. A credit card receipt or canceled check is not adequate documentation. Credit card receipts often do not list the individual items purchased along with a description of the item. This is why you must save your purchase receipts, bills, itemized statements or EOB. Health Care claims cannot be processed for payment without proper supporting documentation.

You may submit up to four (4) purchases on a single Health Care Claim Form, using a separate line for each purchase. Please fax (fastest process) OR mail the documents (keep a copy) but please **DO NOT DO BOTH**.

Place the documents in this order: Health Care Claim Form first, then the supporting documentation. Please do not return the instruction pages with your Form and receipts.

Fax: 866-392-4090 (toll-free) or 678-762-5900

OR

Mail: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853.

Good Receipt

Rx Pharmacy 01-25-2005
(999) 999-9999 CUSTOMER RECEIPT
33945 0034233 3322
Customer: **SARA SAMPLE**
VIGAMOX 0.5% EYE DROPS
Instill one drop 4 times per day Pay: \$ 22.54
Rx Pharmacy, Inc. 123 Somewhere St., Anywhere, CT 99999

Receipt Missing Information

ABC EYE ASSOCIATES
123 MAPLE ST.
SOMEWHERE, CT 99999
DATE: 01-25-2005 TIME: 08:15AM
ITEM: 0034 VIS SALE
ACCT: XXXXXXXXXXXX30
AUTH: 9999
TOTAL: \$ 54.34
I AGREE TO PAY ABOVE AMOUNT
ACCORDING TO CARD ISSUER AGREEMENT
(MERCHANT AGREEMENT IF CREDIT VOUCHER)
X_____

no description of items purchased

Why Providing Documentation Is Important

The IRS has provided strict requirements stating that expenses reimbursed through a Flexible Spending Account must be substantiated using itemized receipts, bills, statements or Explanation of Benefits. All supporting documentation must reflect the vendor name, vendor contact information, purchase/expense incurred date, a description of the expense(s) and the expense amount(s). Health Care claims submitted without eligible documentation cannot be approved for payment, per IRS regulations. If your claim is declined for improper documentation, or if the expense is deemed as ineligible, you will be notified by ADP via U.S. Mail Service.

Filing Multiple Expenses with the Same Service Date, Same Amounts

There may be times when you need to submit multiple expenses for the same amounts that were incurred on the same date. For example, you have two children who are both ill. Both children see the doctor on the same day and both children receive their own prescription with the same co-pay amount. The ADP claims processing system automatically categorizes claims based on the service date and amount and compares those dates and amounts to claims you have already submitted. By filing a separate claim form for each child, the claim that is received and processed second will be marked as a duplicate claim. When submitting multiple claims with identical service date and amounts, you should submit these expenses on the same claim form, whenever possible. If the claims are for eligible dependents, be sure to include the dependent name and date of birth where indicated. This will help to avoid having eligible expenses being inadvertently marked as duplicate claims.

You will receive a notification when a claim is marked as a duplicate. In the event a claim is mistakenly considered a duplicate, please contact your Participant Solution Center to have the claim status corrected. You can review your claims online at www.flexdirect.adp.com.

Resubmitting an FSA Claim When Additional Information is Requested

On occasion, you may be asked to resubmit a claim because information you provided was insufficient. You may have neglected to provide required information such as an itemized receipt or perhaps you just forgot to sign the claim form. In the event you are asked to resubmit a claim, you must submit a new claim form with the requested information.

Depending on the situation, it may not be necessary to resubmit the entire claim. For example, if you filed a claim with four purchases and **only one purchase required additional information**, you would file a new claim for that one purchase with its supporting documentation. You should not resubmit the entire claim with all four purchases as this will result in duplicating the other three purchases and you would receive a letter indicating that these purchases had been duplicated. However, if you **forgot to include receipts** or if you **neglected to sign your claim form**, it would be necessary to resubmit the entire claim with all its supporting documentation.

For questions or additional information on resubmitting claims, please contact your Participant Solution Center or www.flexdirect.adp.com.

Please do not return the instructions pages with your Form and receipts.

The Claim Form is designed so that you may complete the form on your computer by tabbing through the designated fields and typing the required information. If you do not have access to a computer, please use black or blue ink to complete the form. Print clearly and only in the spaces provided. This form will be processed electronically.

Step 1: Complete all Employee Information completely. When completing the Employee Information, you should:

- ① Provide your name as it appears on your paycheck. Please print your name in ALL CAPITAL letters.
- ② Provide your employer's name.
- ③ Include your complete mailing address.
- ④ Include a daytime phone number where you can be reached.
- ⑤ Include your Social Security Number.

Employee Information

(PLEASE PRINT)

Name ① **SARA SAMPLE**

(Please print name in ALL CAPITAL letters)

Employer Name **ABC Company** ②

Address ③ **1234 Main Street**

City **Anytown** ③

State **US** ③

Zip **12345** ③

Daytime Phone ④ **555-222-1234**

Social Security Number ⑤

9 8 9 7 9 6 9 5 9

Instructions: Please use blue or black ink and print like this →

0 1 2 3 4 5 6 7 8 9

Step 2: Complete the Expense Information. Be sure to include only one expense per line provided. **DO NOT** combine multiple expenses on one line. The Claim Form allows you to submit up to four (4) expenses per form. Incomplete claim forms may result in claim denial or a request for more information. When completing the Expense Information, you should:

- ① Provide the date the expense was incurred. This date should match the date on your receipt or EOB.
- ② Provide the name of the physician or merchant from whom the expense was incurred.
- ③ Using the appropriate checkbox, indicate the type of expense incurred.
- ④ If this expense is for a qualified dependent, provide the dependent name, the dependent's relationship to you (use "C" for Child, "S" for Spouse or "O" for other) and the dependent's date of birth.
- ⑤ Provide the total amount for the expense.
- ⑥ Provide the total amount for all line items on the Claim Form

★ **Faxing your claim package is the best submission route and will result in the quickest reimbursement.**

Expense Information

① Start Date of Service			NOTE: Please report <u>only one</u> expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.	⑤ Amount		
MONTH	DAY	YEAR		DOLLARS	CENTS	
0	5	2	6	0	5	1 3 7 0 0 Total ⑥ Expenses → \$ 1 3 7 0 0
NAME OF PROVIDER ② Northside Pediatrics			TYPE OF SERVICE ③			
TYPE OF SERVICE ③ <input type="checkbox"/> DENTAL <input checked="" type="checkbox"/> HEALTH <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION						
DEPENDENT NAME ④ Michael Sample			RELATIONSHIP TO EMPLOYEE C ④	DEPENDENT D.O.B. ④ 01/14/99		

Step 3: Sign and date your Claim Form. Claim forms received without an authorizing signature cannot be processed.

Certification

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. I understand that where an expense is determined to be ineligible, I am responsible for reimbursing the plan for any such expense. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Bills, statements, receipts or other proof of the expenses are attached.

SIGNATURE

Sara Sample

DATE

05/31/05

