WageWorks®
www.wageworks.com

Health Reimbursement Arrangement (HRA)
RETIREE Pay Me Back Claim Form

An electronic claim may be submitted at www.wageworks.com.
TOLL-FREE FAX: (877) 353-9236
Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

DO NOT USE A FAX COVER SHEET
to ensure speedy processing.

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Retiree SSN* (last 4 digits)

Retiree Birth Date (MM/DD)

Employer Name

Spouse/Survivor SSN* (last 4 digits) (if applicable)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

Signature of Account Holder X _____ **Date** _____

I certify that the information on this form is accurate and complete. **I am requesting reimbursement for eligible 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 I have not/will not seek reimbursement of this expense from any other plan or party because I: 1) am required to pay for the premiums through withholding, 2) have paid for the premiums, 3) have already received these products and services. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the WageWorks Web site. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User).

CLAIMS FOR OUT-OF-POCKET EXPENSES

1. One Time Annual Request for Social Security Administration (SSA) Deducted Premiums
(Medicare Part B, Medicare Part C – Medicare Advantage, Medicare Part D – Prescriptions)

Relationship to Account Holder
○ Self
○ Spouse ○ Dependent

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Annual Out-of-Pocket Cost

Patient's Name _____

2. Health Plan Premiums Not Deducted from Your Social Security Check

Relationship to Account Holder
○ Self
○ Spouse ○ Dependent

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Out-of-Pocket Cost

Patient's Name _____

3. Other Expenses ○ Medical ○ Dental ○ Vision ○ Prescriptions ○ Over-the-counter

Relationship to Account Holder
○ Self
○ Spouse ○ Dependent

Service Date (MM/DD/YY)

$ Total Out-of-Pocket Cost

Patient's Name _____

* The last 4 digits of the Social Security Number (SSN) is needed to assist us in identifying your account and to process your claim.

YOU MUST ATTACH A COPY OF APPROPRIATE PROOF OF SERVICE AND PAYMENT FOR EACH AMOUNT ABOVE.

$ **TOTAL THIS FORM**

HEALTH REIMBURSEMENT ARRANGEMENT - ELIGIBLE EXPENSES*

* For a comprehensive list, go to https://www.wageworks.com/employee/health-care/expenses/hra.htm

Services by an M.D. or Licensed Practitioner when medically necessary, including:

- Acupressurist
- Acupuncturist
- Anesthesiologist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Ophthalmologist
- Optometrist
- Osteopath
- Podiatrist
- Psychiatrist/Psychologist
- Psychotherapist
- Surgeon

Medical/Hospital services or other fees:

- Diagnostic services by or under direction of M.D.
- Surgical services by or under direction of M.D.
- X-rays and radiological services for diagnosis or treatment
- Expenses for donating or receiving an organ transplant
- Nursing services for specific medical ailments by an RN or LPN who is not related to employees
- Services of a physical, speech or an occupational therapist
- Ambulance
- Laboratory fees
- Prescription drugs: including insulin, laetrile and birth control pills
- Vitamins and dietary supplements.** Only a quantity of six may be purchased at a time.
- Vaccinations and immunizations
- Orthotics
- Transportation and lodging expenses incurred for medical reasons
- Legal fees paid to authorize treatment for mental illness
- Deductibles and copayments

Other health-related expenses

- Treatment of alcoholism or drug dependency, including expenses for meals and lodging at a treatment center
- Lead-based paint removal in the home
- Smoking cessation programs and related drugs
- Employee plus dependent Medical, Dental, Vision, Rx, Medicare, COBRA or other healthcare insurance premiums.

Dental, vision & hearing

- Dental checkups and care (by a DDS or dental hygienist), including dentists' fees, X-rays, fillings, braces, extractions and dentures
- Orthodontics (usually pro-rated cost attributable to this plan year)
- Cost of guide dog for blind or deaf
- Braille books and magazines (in excess of regular book cost)
- LASIK, Laser, RK surgery or PRK surgery, prescription eyeglasses and contact lenses (including solutions)
- Special devices for the blind (tape recorder, typewriter)
- Hearing aids and care (including batteries)
- Cost of note-taker for a deaf person in school
- Household visual alert & expenses for special phone equipment for a deaf person
- Adapting a television for the deaf

Maintenance & support devices (these require a letter of medical necessity from a licensed physician)

- Support hose and orthopedic shoes (in excess of regular shoe cost)
- Wheelchairs, crutches and wigs for hair loss due to medical treatment
- Oxygen and oxygen equipment
- Cost of equipping an auto for the disabled (in excess of regular auto cost)
- Prostheses and prosthetic supplies
- Colostomy supplies
- Capital expenses - the amounts between the cost of improvements or special equipment installed and the increase in the value of the home
- Psychiatric care - may include costs of supporting mentally ill dependents at a specially equipped center where a dependent receives medical care
- Massage therapy

* If used for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body

** If specifically directed by a licensed practitioner of the healing arts, a written directive is needed

INELIGIBLE EXPENSES (Health Care)

- NEW for 2011 > Over-the-counter (OTC) drug or medicine (unless prescribed by doctor)
- Athletic or health club membership
- Cosmetic procedures and/or surgeries
- Household help
- Any illegal treatment
- Prepayment for services
- Cost of remedial reading classes for a non-handicapped child
- Dancing or ballet, even when recommended by a doctor
- Weight reduction programs for general well-being
- Teeth bleaching or whitening
- Marriage counseling
- Toiletries and sundry items (such as toothpaste, shaving cream, deodorant, shampoo, makeup
- Electric toothbrushes
- Sunscreen under SPF 3
- Insect repellent

WageWorks®
www.wageworks.com

Health Reimbursement Arrangement (HRA)
RETIREE Pay Me Back Claim Form

INSTRUCTIONS
(Do NOT FAX these instructions with your[1] Claim)

PLEASE READ THIS BEFORE SUBMITTING YOUR RETIREE CLAIM FORM

The IRS requires you to substantiate all your claims with appropriate level of documentation in order to be reimbursed. Documentation in total must show that an eligible health care expense has been incurred by you or your eligible dependent. The documentation must show at a minimum

a) the date of coverage or expense

b) the individual covered by health coverage or the individual that incurred the expense

c) name of the provider, merchant, or insurance carrier

d) type of expense (insurance, or other eligible expense, such as medical service, prescription, over the counter medication, etc)

You will also be required to provide additional documentation for private health care premiums to show evidence of payment such as copy of the front and back of a cleared check along with the provider's invoice or bill.

Tips for Completing the HRA Retiree Pay Me Back Claim Form

- Print, or write legibly.
- Complete a separate form for your Dependent or Spouse.
- Make sure you sign the form. If a person holding a Power of Attorney for the Retiree is signing, please make sure he or she signs the form in the following format "*John Smith, Attorney in Fact for Jane Smith*" [Make sure the Power of Attorney is either on file or submitted with the first claim.]
- The account holder Name section should be completed with the Retiree's First and Last Name UNLESS you are a surviving spouse of a Retiree. In that case, the surviving spouse should complete his or her name in the name field.
- If you have a spouse, put the last four digits of your spouse's Social Security Number (SSN) on the claim form to better expedite the claim.
- Keep your original receipts. Submit copies of your receipts with your claim form. If your claim is incomplete, you will be required to resubmit the claim form and receipts. Send legible copies of your receipts.

[1] [As used on this form, "you," "your" or "yours" refer to the Retiree.]

Section 1 – One Time Annual Request for Social Security Administration (SSA) Deduct Premiums (Medicare Part B, Medicare Part C – Medicare Advantage, Medicare Part D – Prescriptions)

- Complete this section if you are requesting reimbursement for a premium that is deducted from your Social Security Check.
- In the "Service Start Date" boxes, enter the first of the month in which you are eligible for Medicare Part B, C or D for this year. In the "Service End Date" boxes, enter the last day of the year. (If eligible for Medicare Part B, C or D on January 1, this will be January 1 to December 31.)
- Enter the annual amount of your Medicare Part B, C or D expense (the monthly amount multiplied by the number of months of coverage.)
- Include a copy of your Social Security "Cost of Living Statement" as proof of your expense (typically mailed starting in November the year before it becomes effective) or any other Medicare statement that clearly indicates your Medicare B, C or D premiums. If the cost is not deducted from your Social Security Check, please fill out Section 2 (Health Care Premiums Not Deducted from Your Social Security Check) on the claim form in order to be reimbursed.
- You will be reimbursed on a pro-rated monthly basis based on your annual premiums. The amount of your monthly reimbursement will not exceed the current balance in your account.

Section 2 – Health Care Premiums Not Deducted from Your Social Security Check

- Complete this section if you are requesting a lump sum reimbursement for Health Care premiums that:

  - were not deducted from your Social Security Check, *and*

  - you have paid to your health plan on an after-tax basis.
- Make sure to provide documentation such as a statement from your insurance carrier, or a copy of the front and back of a cleared check that shows the premiums you have paid.
- The Service Start and End Dates should represent the period of coverage you have paid for and are seeking reimbursement for. These dates should match the statement from your health plan indicating the coverage period you have paid for.
- Keep your original receipts and make copies to fax or mail to WageWorks.
- Note: Pre-tax deductions for premiums from your payroll or your pension plan are not eligible for reimbursement.

Section 3 – Other Expenses

- If you are requesting reimbursement for other out-of-pocket expenses that you have paid for such as co-pays, dental services, eligible over-the-counter items or other eligible expenses, please complete this section.
- Acceptable forms of documentation to show the item was an eligible expense include a receipt or an explanation of benefits from your health plan.
- Documentation should show the date of service, amount of the expense, and a description of the expense.
- When completing the claim form indicate who the expense was for.
- You may add up more than one receipt or expenses incurred for several small eligible expenses and enter that amount on the claim form. When submitting several receipts or pieces of documentation please circle the expense amounts, date of service and description on each receipt or supporting documentation. Print the earliest service start date on the claim form if requesting reimbursement for several expenses. You will also need to indicate on the claim form who the expenses were for. (Dependent)