Health Reimbursement Arrangement Claim Form

Reimbursement of claims are subject to the provisions of your employer's plan documents and applicable laws and regulations.

BlueCross BlueShield of Delaware

BC 31490-19-FSAx2 (rev. 5/21/07)

- Please see the reverse side for instructions on completing this claim form.
- PRINT all requested information (except signature).
- Retain a copy of this completed form and documentation for your records.

Employee's Name—Last, First, Middle Initial	**Employee's Social Security Number**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address ☐ Check this box if this is a new address.		
Daytime Telephone Number ( )	**Employer**	

Use this form to request reimbursement only for expenses not covered by any health insurance, and as defined in your employer's plan documents. See employer's plan documents for the plan year for this employer-provided plan.

If you have any questions:
Visit—www.bcbsde.com (select Flexible Benefits)
Email—Flex@bcbsde.com
Fax—302.421.8883
Call—302.421.8970 or 1.800.559.FLEX (3539), 7:30 AM–4:30 PM (ET)

PROVIDER OF SERVICE	PERSON RECEIVING SERVICE AND THEIR SOCIAL SECURITY NUMBER	BIRTH DATE	RELATION-SHIP	DATE EXPENSE INCURRED	EXPENSE TYPE CODE*	REIMBURSEMENT REQUEST AMOUNT
		/ /		/ /		$
		/ /		/ /		
		/ /		/ /		
		/ /		/ /		
		/ /		/ /		

Expense Type Codes:** **D**=Dental** **P**=Prescription Drugs** **H**=Hearing** **V**=Vision** **HC**=Health Care ***if allowed by plan document

Total Reimbursement Requested (Minimum Total of $50.00) $

The terms health care expenses, claims, insurance and employer-sponsored health care program include expenses, claims, insurance and employer-sponsored programs for medical, dental, vision and prescription drugs.

I CERTIFY THAT: (1) The health care expenses claimed above are not eligible for payment or reimbursement by any employer-sponsored health care program. **(2)** The expenses claimed above have not been paid or reimbursed by, and have not been and will not be submitted for payment or reimbursement by, any other plan covering health benefits, including but not limited to any individual or group health insurance or any health care flexible spending account, health reimbursement arrangement, health savings account, including coverage under a spouse's or dependent child's plan. **(3)** Any expenses claimed above for a person other than myself were incurred by an individual who was my spouse or dependent child, as defined in the plan document and for federal income tax purposes, at the time the expense was incurred. **(4)** The expenses claimed above have not been and will not be taken as a deduction on my federal income tax return for the year paid or incurred. **(5)** The expenses claimed above are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and are not cosmetics or toiletries. **(6)** Expenses incurred in one plan year may be reimbursed in a later plan year, only if the employer's plan documents so provide, and if: **(a)** the employee was covered under the employer's health reimbursement arrangement when the expense was incurred; and **(b)** if the expense was for a spouse and/or a dependent child, such individual was the spouse and/or child of the employee at the time the expense was incurred.

Signature _____ Date: _____

Attach copies of the required documentation to this form and send to:

Blue Cross Blue Shield of Delaware
Flexible Benefits Department
P.O. Box 8737
Wilmington, DE 19899-8737

Instructions for Completing the Health Reimbursement Arrangement Claim Form

Questions?

Contact us using one of these convenient methods:

Visit: www.bcbsde.com (select Flexible Benefits)
Email: Flex@bcbsde.com
Fax: 302.421.8883
Call: 302.421.8970 or 1.800.559.FLEX (3539), Monday–Friday, 7:30 am to 4:30 pm (ET)

To prevent delays in processing your claim, please complete this form correctly.

Name, Social Security Number, Address: Enter your name, Social Security number and address as it appears on your employer's payroll records.

Daytime Telephone Number: Enter your daytime telephone number.

Employer: Enter the name of your employer.

Provider of Service: Enter the name of the person or facility that provided the service: for example, the doctor, pharmacy, etc. Use a separate line for each expense.

Person Receiving Service and Their Social Security Number: Enter your name, or if your spouse or dependent child, his or her name, and the individual's Social Security number.

Birth Date: Enter the birth date of the person receiving service.

Relationship: Enter the individual's relationship to you: for example, your daughter, son, or spouse.

Date Expense Incurred: Enter the date the expense was incurred, not the date it was paid. ***Note:*** For Prescription Drugs, the incurred date may be the date the expense was paid.

Expense Type: Enter the code for the type of expense incurred:

D=Dental
H=Hearing
HC=Health Care
P=Prescription Drugs
V=Vision

Reimbursement Request Amount: Enter the amount of the incurred expense that is eligible for reimbursement. This must agree with the documentation submitted.

Total Reimbursement Requested: Add the amounts of reimbursement requested and enter the total. The total must be a minimum of $50, unless your account balance is less than $50.

Signature and Date: Sign and date the form.

Documentation Required: You must attach copies of the required documentation to receive reimbursement.

For health, dental, vision, or hearing care expenses, attach a copy of the Explanation of Benefits form, denial letter or other documentation you received from the insurance company(ies) or the provider of service, if insurance is not involved. The documentation must include the name of the provider, the name of the person receiving service, the type of service, the incurred date and the provider's charge for the service. (No VISA/MC receipts or cancelled checks.)

For prescription drug expenses, a prescription statement from the pharmacy — not just a receipt for payment. ***Example:*** a bag receipt with Rx number.

Send the completed form with documentation attached to:

Blue Cross Blue Shield of Delaware
Flexible Benefits Department
PO Box 8737
Wilmington, DE 19899-8737