

Reimbursement Instructions – Please Review

Eligible Services and Documentation Requirements:

The expense must be a health related expense incurred by you or one of your tax dependents. This means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body. Expenses must be medically indicated and not for cosmetic purposes or general good health.

Supporting documentation must accompany this request form. We reserve the right to request additional documents as necessary. Generally, supporting documentation includes the following:

An itemized bill showing dates of service, expense description, provider's name, patient's name and amount of service **or** a copy of any "Explanation of Benefits" (EOB) or Payment Voucher from any insurance plan under which the claimant is covered.

Balance forward statements, checks (copies of initial or cancelled checks), bank statements and credit card receipts are **not** acceptable. Each services must be substantiated by information providing "what, where, who and how much". Incomplete information will result in delay or rejection of your request.

Please ensure that all documents are legible. Once received, claims are scanned (similar to photocopying). Documents that are too light, too dark or fonts that are too small will cause delay. We suggest sending us a photocopy of receipts and retaining the original for your records. Please do not highlight documents as this will not show on scanned images.

Use special caution when submitting ledger bills from your provider. They should be **clearly marked** as to the date of service, expense description and fee. Only services incurred (the actual date the service is rendered) while you are covered will be payable. Ledgers that are not clear may cause delay or denial of your request.

Only one clear piece of documentation is needed for each individual expense. For instance, an EOB will give us all needed information and additional receipts or billings for this same service need not be submitted in addition.

Actual dates of care must be indicated on the claim form. The IRS allows reimbursement for services when the care is provided, which may not be the actual date that the patient pays or is formally billed for the charges.

Retain a copy of the reimbursement request form and copies of supporting documents for your records, as those submitted will not be returned. A request for claim copies will incur a \$1.00 per page charge.

Payments:

Reimbursements are paid to you, and may not be assigned to any other person. Checks, Direct Deposit Advise and Explanations of Payment will be mailed to the home address on file. *Any address changes must be submitted in writing.*

Request Submission:

Complete the Health Care Spending Account Reimbursement form (including total reimbursement requested, signature and date) and submit it along *with your supporting documentation* to:

Personal Choice Account
PO Box 3199
Portland, OR 97208-3199
Or fax to: (503) 225-5353 or 1(800) 979-8987

Questions:

Email pca@regence.com or call us at (503) 412-5688 or (800) 334-4340

PERSONAL CHOICE ACCOUNT

Flexible Benefits Administration

Health Care Reimbursement Request Form

Complete ALL information in this section. Incomplete forms may result in delay or denial.

| | |
|--|---|
| Employer / Group Name | Preferred method of communication (provide email or phone number) |
| Participant Name (Last, First, MI) <i>PLEASE PRINT CLEARLY</i> | Social Security Number or Alternate Identification Number |

List total amount of reimbursement requested for each type of service category. Also list the earliest (FROM) and latest (TO) date that services in this category were rendered (see submission instruction) in a month-day-year format. **Failure to do so may result in delay or denial.**

| | | |
|--|---------------------------------|----------|
| Medical/Vision Reimbursement Total | From ___-___-___ To ___-___-___ | \$ _____ |
| <i>Attach EOB's or Itemized bills showing patient, provider, date of service, procedure, and charge amounts. Use actual service date.</i> | | |
| Dental Reimbursement Total | From ___-___-___ To ___-___-___ | \$ _____ |
| <i>Attach EOB's or Itemized bills showing patient, provider, date of service, procedure and charge amounts. Use actual service date.</i> | | |
| Prescription Drug Reimbursement Total | From ___-___-___ To ___-___-___ | \$ _____ |
| <i>Attach pharmacy receipts showing the RX Number (prescription number), patient, date purchased and charge amount.</i> | | |
| Massage Therapy Reimbursement Total | From ___-___-___ To ___-___-___ | \$ _____ |
| <i>Attach EOB, itemized bill or provider statement showing patient, provider, date of service and charge amount. Use actual service date. We require a letter of medical necessity each plan year. Check here if letter is on file with our office <input type="checkbox"/></i> | | |
| Over-The-Counter Item Reimbursement Total | From ___-___-___ To ___-___-___ | \$ _____ |
| <i>Attach retail store receipt that shows the name of item purchased. If the item name is not on the receipt please write it in here: _____ . Use actual purchase date. For multiple items please write directly on the receipt.</i> | | |
| Orthodontic Reimbursement Total | From ___-___-___ To ___-___-___ | \$ _____ |
| <i>Attach proof of payment which shows patient, provider, and payment amounts.</i> | | |

TOTAL REIMBURSEMENT REQUESTED \$ _____

After reading the claim submission instructions and completing this form read and sign the statement below. Unsigned requests will be rejected.

The Internal Revenue Code permits the Personal Choice Account to provide reimbursement only for medical care which means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Neither the Personal Choice Account nor the Plan Sponsor are liable to the participant or any other entity for taxes, interest, penalties or other consequences which may be assessed by any taxing authority for disallowed expenses. Furthermore, neither entity will be responsible for banking charges that may be incurred.

I request reimbursement for the attached expenses under the Health Care Flexible Spending Account. I certify that I or my eligible tax dependents have incurred these services and that they are reimbursable under the terms of my employer's Health Care Flexible Spending Account Program. I understand that I am solely responsible for the validity of claims submitted to my Flexible Spending Account. I certify that the claimed expenses are incurred for medical care as defined above. I understand that this alone does not guarantee the reimbursement of services. Furthermore, these services have not been reimbursed prior to this submission and are not reimbursable by any other source.

PLAN PARTICIPANT'S SIGNATURE (REQUIRED)

DATE

If you have any questions regarding your Flexible Spending Account or how to complete this form, please call 503-412-5688 or toll free 1-800-334-4340. You may also email us at pca@regence.com or visit our website at www.personalchoiceaccount.com

Submit signed reimbursement form to:

Personal Choice Account

PO Box 3199

Portland, OR 97208-3199

Or fax to: (503) 225-5353 or 1(800) 979-8987