

Health Care Reimbursement Account (HRA)
Request Form Instructions

Please completely read the following instructions before submitting your claim.

Deductible – The amount that a participant is responsible for before a third party will assume any liability for payment of benefits.
(Example: \$500.00 medical expense, \$200.00 deductible is taken before benefits can be paid. The \$200.00 is reimbursable.)

Co-Insurance – The percentage of a covered expense that the participant must pay (after the deductible).
(Example: The dental insurance carrier pays 50% on a crown. The remaining 50% is your co-insurance, which would be reimbursable.)

Co Pay – Participant's share of the covered expense after the plan has paid. Often this co payment is collected at the time the services are rendered.
(Example: You must pay the doctor \$5.00 for each office visit. This \$5.00 co pay is reimbursable.)

1. 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.
2. Reimbursements are paid to you, and may not be assigned to any other person. Checks and Explanations of Reimbursement (EOR's) will be mailed to the home address on file. **Any address changes must be submitted in writing to Personal Choice Account.**
3. Supporting documentation must accompany this request form. We reserve the right to request additional documents as necessary. Supporting documentation includes the following:

For reimbursement of a **deductible, co pay or co-insurance expense**, a copy of any "Explanation of Benefits" (EOB) statement from any insurance plan under which the claimant is covered is required.

For **massage** reimbursement an itemized bill showing dates of service, expense description, provider's name, patient's name and amount of service is required. A licensed provider must preform services and the receipt should include the medical diagnosis (dx code). In lieu of a diagnosis code a letter of medical necessity may also be submitted.

For **orthodontic** reimbursement an itemized bill, visit history or payment coupon showing the patient, provider, date of service and charge amounts is required. In addition, for the first submission of a treatment plan, an orthodontic worksheet is required. *Information is available at www.personalchoiceaccount.com regarding orthodontic reimbursement.*

Over-The-Counter reimbursement requires proof of purchase, date of purchase and a clear explanation as to the item and it's medical necessity.

PLEASE NOTE: BALANCE FORWARD STATEMENTS, CHECKS (COPIES OF INITIAL AND/OR CANCELLED CHECKS) BANK STATEMENTS AND CREDIT CARD RECEIPTS ARE NOT ACCEPTABLE. 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.

4. 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

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

PERSONAL CHOICE ACCOUNT

Flexible Benefits Administration

Original Submission

Re-submission

Health Care Reimbursement Account (HRA)
Request Form

Complete ALL information in this section. Incomplete forms may result in delay or denial. Please use black ink only.

Employer Company Name	Plan Year 200
Participant Name (Last, First, MI)	Employee ID Number (REQUIRED)

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. Failure to do so may result in delay. **Please see the "instructions" page for the definition of deductible, co-pay and co-insurance. EOB's are required for these items**

Medical HRA Reimbursement	From _____ To _____	<input type="checkbox"/> Deductible \$ _____
		<input type="checkbox"/> Co-Pay \$ _____
		<input type="checkbox"/> Co-Insurance \$ _____
		TOTAL \$ _____
Dental HRA Reimbursement	From _____ To _____	<input type="checkbox"/> Deductible \$ _____
		<input type="checkbox"/> Co-Pay \$ _____
		<input type="checkbox"/> Co-Insurance \$ _____
		TOTAL \$ _____
Vision HRA Reimbursement	From _____ To _____	<input type="checkbox"/> Deductible \$ _____
		<input type="checkbox"/> Co-Pay \$ _____
		<input type="checkbox"/> Co-Insurance \$ _____
		TOTAL \$ _____
Prescription HRA Reimbursement	From _____ To _____	<input type="checkbox"/> Deductible \$ _____
		<input type="checkbox"/> Co-Pay \$ _____
		<input type="checkbox"/> Co-Insurance \$ _____
		TOTAL \$ _____
Massage Reimbursement	From _____ To _____	TOTAL \$ _____
Orthodontic Reimbursement	From _____ To _____	TOTAL \$ _____
Over-The-Counter Reimbursement	From _____ To _____	TOTAL \$ _____

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 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. 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 Reimbursement Account Plan. 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 Reimbursement 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

DATE

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