

## How To File a Health Care Claim

To successfully complete a Health Care reimbursement request, you must submit a *Health Care Claim Form* along with a documentation that clearly shows an eligible item(s) or service(s) was incurred. To submit for reimbursement of a Health Care expense(s), please:

1. Complete a *Health Care Claim Form*
2. Attach itemized documentation and, if required, your physician's statement of necessity<sup>(a)</sup>
3. Send us the Form and the documentation



<sup>(a)</sup> Some items not typically covered under an FSA plan may be eligible for reimbursement with a qualifying physician's statement of medical necessity. Please see Page 2 of these instructions for additional information on medical necessity.

The *Claim Form* must be completed entirely, dated and signed. The documentation 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 eligible documentation.

Retain your original documentation or EOB and send clear photocopies with your Claim Form to ADP. 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**.

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

**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.**

OR

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

Good Receipt

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

Receipt Missing Information

<b>ABC EYE ASSOCIATES</b>	
123 MAPLE ST. SOMEWHERE, CT 99999	
DATE: 01-25-2005	TIME: 08:15AM
ITEM: 0034 VIS SALE ACCT: XXXXXXXXXXXX30 AUTH: 9999	
<b>TOTAL:</b>	<b>\$ 54.34</b>
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 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 via U.S. Mail Service.

### Statements of Medical Necessity

In some cases, items or services that are not typically eligible under an FSA plan may be reimbursable when accompanied by a qualifying physician's statement of medical necessity. To qualify for reimbursement, the physician's statement must include the item or service description, the specific medical condition the item or service is intended to treat or alleviate and the duration of the required treatment. You should retain a copy of the physician's statement for as long as you will be filing claims for this item or service because the statement must be included each time you file a claim for the expense.

Some examples of items or services (and some of their treatment purposes) that would require a physician's statement for eligibility are:

- St. John's Wart (over-the-counter, used for depression)
- Oatmeal Bath (over-the-counter, used for skin infections or disorders)
- Iron Supplement (over-the-counter, used for anemia, Chronic Fatigue Syndrome or other blood disorders)
- Dandruff Shampoo (over-the-counter, used for scalp condition or skin fungus)
- Melatonin (over-the-counter, used for chronic insomnia or other sleep disorders)
- Toothpaste or Mouth Rinse (over-the-counter, used for sensitive teeth or gum infections)
- Teeth Whitening (professionally administered to resolve darkening/staining from infection or long-term antibiotic use, does not apply to over-the-counter whitening products such as strips, rinses or toothpastes)
- Mattress or Adjustable Bed (used for muscular, skeletal or circulatory disorders)
- Health Club Membership (used for weight loss due to extreme obesity or underlying diseases such as diabetes, for cardiac rehabilitation or for degenerative muscle/joint diseases)

Many other items can qualify for reimbursement with a physician's statement. If you are uncertain about the eligibility of a specific item or if you have additional questions about medical necessity, please contact your Participant Solution Center or visit our website at <https://www.flexdirect.adp.com/mifsa/> prior to making the purchase.

NOTE: Your employer's plan may limit the eligibility of certain items.

### 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. It seems logical that you would file a separate claim form for each child. However, the ADP Claim System automatically reads 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.

In the event a valid claim is entered as a duplicate, please contact your Participant Solution Center to have the claim status corrected. You will receive a notification when a claim is marked as a duplicate. You can also verify the status of your claims on our website at <https://www.flexdirect.adp.com/mifsa/>.

### Resubmitting an FSA Claim When Additional Information is Requested

On occasion, you may be asked to resubmit a claim because information you provided was not sufficient, you neglected to provide required information such as a qualified documentation 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 visit our website at <https://www.flexdirect.adp.com/mifsa/>.

**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 Include your complete mailing address.
- ③ Include a daytime phone number where you can be reached.
- ④ Include your Employee ID. **Remember to include leading zeros ("0") before your Employee ID to meet the required 10 digits.**

**Employee Information** (PLEASE PRINT)

Name **SARA SAMPLE** ① Employer Name **State of Michigan**  
(Please print name in ALL CAPITAL letters)

Address **1234 Main Street** ②

City **Anytown** ② State **US** ② Zip **12345** ② Daytime Phone **555-222-1234** ③

Employee ID ④

0	0	0	0	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(s) 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(s) was incurred.
- ③ Using the appropriate checkbox, indicate the type of expense(s) incurred.
- ④ If this claim 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 this expense.
- ⑥ Provide the total amount for all line items on this Claim Form.

**Expense Information**

<b>① Start Date of Service</b>	NOTE: Please report <u>only one</u> expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.	<b>⑤ Amount</b>										
<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <th style="width: 33%;">MONTH</th> <th style="width: 33%;">DAY</th> <th style="width: 33%;">YEAR</th> </tr> <tr> <td style="text-align: center;">0 5</td> <td style="text-align: center;">2 6</td> <td style="text-align: center;">0 5</td> </tr> </table>	MONTH	DAY	YEAR	0 5	2 6	0 5	NAME OF PROVIDER ② <b>Northside Pediatrics</b> TYPE OF SERVICE ③ <input type="checkbox"/> DENTAL <input checked="" type="checkbox"/> HEALTH <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <th style="width: 50%;">DOLLARS</th> <th style="width: 50%;">CENTS</th> </tr> <tr> <td style="text-align: center;">1 3 7</td> <td style="text-align: center;">0 0</td> </tr> </table>	DOLLARS	CENTS	1 3 7	0 0
MONTH	DAY	YEAR										
0 5	2 6	0 5										
DOLLARS	CENTS											
1 3 7	0 0											
DEPENDENT NAME ④ <b>Michael Sample</b>	RELATIONSHIP TO EMPLOYEE ④ <b>C</b>	DEPENDENT D.O.B. ④ <b>01/14/99</b>										
Total Expenses ⑥ → \$		1 3 7 0 0										

**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



HCID-02



# Health Care Spending Account Claim Form

*This document and any attachments are intended solely for the use of the sender and ADP and may contain information that is privileged and confidential. If you are not the intended recipient or its authorized representative, you are hereby notified that dissemination of this information is strictly prohibited. If you received this information in error, notify the sender immediately and destroy this document and all supporting attachments.*

### Tips to Remember

1. Sign your Claim Form.
2. Fax your Claim Form *without* a cover page, followed by a copy of all supporting documentation including itemized receipts, bill or statements, physician's statement (if required) and/or Explanation of Benefits (EOB).
3. *Do not* include the instructions pages with your submission.

**Remember! You must include leading zeros ("0") before your Employee ID to meet the required 10 digits. (EXAMPLE: 0000654321)**

### Employee Information

(PLEASE PRINT)

Name \_\_\_\_\_ Employer Name **State of Michigan**  
(Please print name in ALL CAPITAL letters)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Employee ID

Grid for entering Employee ID (10 digits)

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



Grid for entering digits 0-9

### Expense Information

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.	Amount	
MONTH	DAY	YEAR		DOLLARS	CENTS
[Grid for Start Date]			NAME OF PROVIDER	[Grid for Amount]	
[Grid for Start Date]			TYPE OF SERVICE DENTAL HEALTH VISION PRESCRIPTION	[Grid for Amount]	
[Grid for Start Date]			DEPENDENT NAME RELATIONSHIP TO EMPLOYEE DEPENDENT D.O.B.	[Grid for Amount]	
[Grid for Start Date]			NAME OF PROVIDER	[Grid for Amount]	
[Grid for Start Date]			TYPE OF SERVICE DENTAL HEALTH VISION PRESCRIPTION	[Grid for Amount]	
[Grid for Start Date]			DEPENDENT NAME RELATIONSHIP TO EMPLOYEE DEPENDENT D.O.B.	[Grid for Amount]	
[Grid for Start Date]			NAME OF PROVIDER	[Grid for Amount]	
[Grid for Start Date]			TYPE OF SERVICE DENTAL HEALTH VISION PRESCRIPTION	[Grid for Amount]	
[Grid for Start Date]			DEPENDENT NAME RELATIONSHIP TO EMPLOYEE DEPENDENT D.O.B.	[Grid for Amount]	
[Grid for Start Date]			NAME OF PROVIDER	[Grid for Amount]	
[Grid for Start Date]			TYPE OF SERVICE DENTAL HEALTH VISION PRESCRIPTION	[Grid for Amount]	
[Grid for Start Date]			DEPENDENT NAME RELATIONSHIP TO EMPLOYEE DEPENDENT D.O.B.	[Grid for Amount]	
<p>To Expedite Processing Please Fax Your Claim To  <b>1-(866) 392-4090 (toll-free)</b>            Or Mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853</p>				<p>Total Expenses → \$ [Grid for Total Amount]</p>	

### 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 \_\_\_\_\_

DATE \_\_\_\_\_