WageWorks Pay Me Back Claim Form Instructions

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important. To ensure we are able to process your reimbursement, please fully complete the WageWorks Pay Me Back (PMB) claim form. Submit your claim form along with your complete documentation of the expense. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

Tips for Filling out the Pay Me Back Claim Form

- Read every box and provide all requested information pertaining to you and your claim.
- Provide the legal name your employer has for you in their official records, not your nickname.
- Provide your ID Code which is usually the last four digits of your SSN.
- Make sure to total all claim line dollar amounts and enter it in the box at the bottom of the form.
- Make sure you sign the form. If the **account holder's signature** is not present, we cannot process your claim.

Things to Remember When Including Receipts

- The receipt or documentation must contain:
  - **Provider Name** – Who delivered the service or, if a purchase, where item was purchased.
  - **Date of Service** – Date services occurred or date item was purchased.
  - **Service Description** – Detailed description of what service or product was paid for. Bag tag is sufficient for prescriptions.
  - **Amount** – The amount paid for the services or product and/or the portion not reimbursed through your insurance carrier.
  - **Patient Name** – Person who received the service or who the item is for. For retail store purchases this may be excluded.
- Include a receipt for every expense.
- Explanation of Benefits (EOB's) are recommended if your insurance covered a part of the expense.
- If submitting handwritten receipts it must have stamped provider information.
- Cancelled or Carbon copies of checks are not acceptable forms of receipt documents. Please do not submit.
- Please do not include carbon copy receipts.
- Do not send your original receipts; save them for the IRS.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- Do not use a highlighter to highlight the dollar amount on the receipt.

Tips for Submitting the Pay Me Back Claim Form by Fax

- Do not use a cover page.
- Use a high-speed fax machine with a transmission speed of at least 9.6 kbps or 15 sec. per page.
- Please wait 2 business days after submitting your claim before contacting WageWorks for your claim status.
- You can also verify the claim status online at www.wageworks.com.
- You will be notified via email of the status of your claim if we have a valid email address on file.
- Make a copy of the form and all attachments for your records.
- If sending Card Verification Form (CVF) along with your Health Care PMB claim, always put the Card Verification Form in front of the PMB claim so we can process it first.
- Do not combine and submit a co-workers claim with yours.
- Return the original form and copies of your receipts to WageWorks via fax or U.S. Mail.

FAX: (877) 353-9236, or mail your claims to: Claims Administrator, PO Box 14053, Lexington, KY 40512

WageWorks®

www.wageworks.com

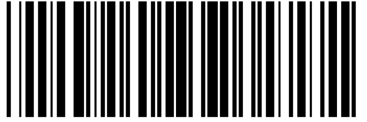
Health Care Account

Pay Me Back Claim Form

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

ID Code (last 4 digits)*

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

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 have not and will not seek reimbursement of this expense from any other plan or party. 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? link).

Signature of Account Holder X ______________________ **Date** __________

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

1

Rx | Dental | Psych / therapy | Ortho
Co-payment | Over-the-counter | Chiro | Hospital
Office visit | Vision | Lab | X-ray
Other: ____________________

Patient's Name

Service Start Date (MM/DD/YY)

Self | Qualifying Child
Spouse | Qualifying Relative
Other: ____________

Relationship to Account Holder

$ ___,___ Out-of-Pocket Cost

2

Rx | Dental | Psych / therapy | Ortho
Co-payment | Over-the-counter | Chiro | Hospital
Office visit | Vision | Lab | X-ray
Other: ____________________

Patient's Name

Service Start Date (MM/DD/YY)

Self | Qualifying Child
Spouse | Qualifying Relative
Other: ____________

Relationship to Account Holder

$ ___,___ Out-of-Pocket Cost

3

Rx | Dental | Psych / therapy | Ortho
Co-payment | Over-the-counter | Chiro | Hospital
Office visit | Vision | Lab | X-ray
Other: ____________________

Patient's Name

Service Start Date (MM/DD/YY)

Self | Qualifying Child
Spouse | Qualifying Relative
Other: ____________

Relationship to Account Holder

$ ___,___ Out-of-Pocket Cost

4

Rx | Dental | Psych / therapy | Ortho
Co-payment | Over-the-counter | Chiro | Hospital
Office visit | Vision | Lab | X-ray
Other: ____________________

Patient's Name

Service Start Date (MM/DD/YY)

Self | Qualifying Child
Spouse | Qualifying Relative
Other: ____________

Relationship to Account Holder

$ ___,___ Out-of-Pocket Cost

5

Rx | Dental | Psych / therapy | Ortho
Co-payment | Over-the-counter | Chiro | Hospital
Office visit | Vision | Lab | X-ray
Other: ____________________

Patient's Name

Service Start Date (MM/DD/YY)

Self | Qualifying Child
Spouse | Qualifying Relative
Other: ____________

Relationship to Account Holder

$ ___,___ Out-of-Pocket Cost

* Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

$ ___,___ **TOTAL THIS FORM**

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

MORE EXPENSES? Complete another form.