

Instructions

1. Employee must complete **Employee Information**.
 2. Complete **Claim Information** in its entirety. Please ensure your supporting documentation clearly indicates the requested amount.
 3. Check the appropriate box in Supporting Documentation section and attach Acceptable Supporting Documentation as described below. (When attaching small receipts, we suggest you tape them to a standard size sheet of paper.)
 - a) Itemized Statement or bill from your provider including:
 - Provider name
 - Patient name
 - Description of service
 - Original date of service (the date of service, not the date of payment must fall within the plan year for which you are enrolled and while you are a participant in the plan)
 - Patient portion of charge(s); or
 - b) Explanation of Benefits (EOB) from your insurance carrier; or
 - c) Pharmacy Statement including:
 - Patient name
 - Prescribing physician
 - RX number
 - Name of the drug
 - Date the RX was filled
 - Co-payment amount
- *Unacceptable Documentation includes the following:**
- Cancelled Checks
 - Credit / cash receipts (An itemized cash register receipt is acceptable for eligible over-the-counter expenses)
 - Balance forward statements

4. Sign and date **Employee Certification**.

5. **Submit Claims To:**

Empire BCBS

Fax: (888) 347-5212 Phone: (877) 378-2448

P.O. Box 660165

Dallas, TX 75266-0165

Eligible expenses are defined in your Summary Plan Description. Such expenses include but are not limited to: Acupuncture, Alcohol & Drug Rehabilitation (inpatient treatment only), Ambulance, Artificial Limbs, Artificial Insemination/Invitro Fertilization/Fertility Enhancement, Blood Pressure Monitoring Devices, Body Scan, Birth Control Pills/Condoms/Spermicide, Chiropractor, Co-Insurance and Deductible, Contact Lenses & Cleaning Solutions, Crutches, Dental Treatment, Dentures, Diagnostic Tests, Eye Exam, Eye Glasses/Prescription Glasses, Flu Shots, Hearing Devices, Hospital Services, Immunizations (e.g., well-baby shots), Insulin, Laboratory fees, Lamaze Classes relating to childbirth, Laser Eye Surgery / Lasik, Learning Disability Treatment, Medical Alert Bracelet/Necklace, Obstetric Treatment, Orthodontia, Over-the-counter pregnancy tests, Over-the-Counter Medications to treat a specific medical condition, Oxygen, Physical Exams, Physical Therapy, Podiatry Treatment, Prescription Drugs, Psychiatric Treatment, Psychological Treatment, Radial Keratotomy, Surgery & Related Expenses, Tubal Ligation or Vasectomy, X-rays.

Ineligible expenses include but are not limited to: Cosmetic Surgery and Procedures, Expenses for services rendered outside the coverage period, Expenses reimbursed by an insurance provider or another health plan, Hair Loss Items, Herbs/Vitamins/Supplements that do not require a prescription for use, Insurance Premiums, Long Term Care Services, Marriage Counseling, Personal Use Items, Teeth Whitening.

Employee Information

Employer Name _____
 Employee Name _____ Account Number / SSN _____
 Street Address _____ Daytime Phone Number _____
 City _____ State _____ Zip Code _____

Do you want to know if Empire received and processed your claim? Please provide your e-mail address:

E-mail Address _____

Claim Information

Patient Name	Date of Service	Type of Service	Requested Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
Total Amount Requested (continue on additional page if necessary)*			\$ _____

Supporting Documentation

Attach Supporting Documentation (*see list of acceptable documentation on instructions page).

- I have attached copies of Explanation of Benefits (EOBs) for deductible and coinsurance requests.
- I have attached itemized bills for expenses not covered by medical, dental or vision insurance.

Employee Certification

- I certify the expenses listed for reimbursement are eligible healthcare expenses under the Internal Revenue Code and my employer's Health Care Spending Account (HCSA);
- I certify the services listed above have been received by me, my spouse, or my eligible dependent on the dates indicated;
- I certify these expenses have not been submitted previously for reimbursement under the HCSA and such items have not and will not be covered by any other plan or program of any employer or other person;
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- I understand that I may be required to provide further details about some expenses, including a statement from a medical practitioner that the expense is for a specific medical condition;
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the HCSA for the improperly paid amount. I further understand failure to repay the HCSA could result in adverse income tax consequences;
- By providing my e-mail address, I authorize Empire to send account information to me via e-mail.



Employee Signature _____ Date _____

Medical expenses which have been reimbursed under this plan are not deductible for income tax purposes.

* Only the total amount supported by the attached documentation (receipts) will be paid.

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