WageWorks Pay Me Back Claim Form Instructions

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important, but in order for us to process it and your reimbursement quickly and fully, we need you to completely and accurately fill out and submit the WageWorks Pay Me Back (PMB) claim form. To help you, we've provided the below guidelines. Please follow them when completing and submitting 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 your official records, not your nickname
- Make sure to total the reimbursement amount and enter it at the box at the bottom of the form
- Make sure you sign the form

Things to Remember When Including Receipts

- Include a receipt for every expense
- A canceled check is not an acceptable form of receipt
- Each receipt must include the date(s) of service
- Do not send 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
- If sending Card Verification form 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-worker's claims with yours

WageWorks®

www.wageworks.com

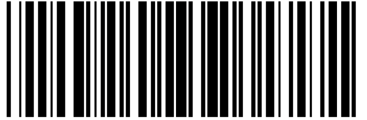
Health Care Account

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 | Co-payment | Office visit | Other: ____

Dental | Over-the-counter | Vision

Psych / therapy | Chiro | Lab

Ortho | Hospital | X-ray

Service Start Date (MM/DD/YY)

$ Out-of-Pocket Cost

Self | Qualifying Child | Spouse | Qualifying Relative | Other: ____

Patient's Name

Relationship to Account Holder

2

Rx | Co-payment | Office visit | Other: ____

Dental | Over-the-counter | Vision

Psych / therapy | Chiro | Lab

Ortho | Hospital | X-ray

Service Start Date (MM/DD/YY)

$ Out-of-Pocket Cost

Self | Qualifying Child | Spouse | Qualifying Relative | Other: ____

Patient's Name

Relationship to Account Holder

3

Rx | Co-payment | Office visit | Other: ____

Dental | Over-the-counter | Vision

Psych / therapy | Chiro | Lab

Ortho | Hospital | X-ray

Service Start Date (MM/DD/YY)

$ Out-of-Pocket Cost

Self | Qualifying Child | Spouse | Qualifying Relative | Other: ____

Patient's Name

Relationship to Account Holder

4

Rx | Co-payment | Office visit | Other: ____

Dental | Over-the-counter | Vision

Psych / therapy | Chiro | Lab

Ortho | Hospital | X-ray

Service Start Date (MM/DD/YY)

$ Out-of-Pocket Cost

Self | Qualifying Child | Spouse | Qualifying Relative | Other: ____

Patient's Name

Relationship to Account Holder

5

Rx | Co-payment | Office visit | Other: ____

Dental | Over-the-counter | Vision

Psych / therapy | Chiro | Lab

Ortho | Hospital | X-ray

Service Start Date (MM/DD/YY)

$ Out-of-Pocket Cost

Self | Qualifying Child | Spouse | Qualifying Relative | Other: ____

Patient's Name

Relationship to Account Holder

* 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.