

Health Care Spending Account Claim Form**Send Claim to:**FISERV HEALTH MS 6230
PO BOX 8022
WAUSAU WI 54402-8022
www.fiservhealthservices.com
Phone: 1-800-826-9781 X 2189
Fax: 1-877-390-4782**TO: Claim Administration****PERSONAL INFORMATION**

Employee's Last Name _____ First Name _____

Social Security Number _____

ACCOUNT INFORMATION

- THE DEADLINE FOR FILING CURRENT YEAR CLAIMS FOR REIMBURSEMENT UNDER YOUR HEALTH CARE SPENDING PLAN IS 120 DAYS AFTER THE END OF PLAN YEAR.
- WHEN SUBMITTING CLAIMS FOR THE REIMBURSEMENT ACCOUNT YOU MUST SUBMIT DOCUMENTATION WITH THIS FORM!

PART A: REIMBURSEMENT INFORMATION FOR OTHER THAN OVER-THE-COUNTER MEDICATIONS

(See Eligibility Information on Reverse Side)

	Name of Supply or Provider of Service or Supply	Service or Supply Purchase Date (MM/DD/YY)	Expense Code*	Amount for which You are Requesting Reimbursement
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

Part A Total Reimbursement Request Amount \$ _____

*Expense Codes: HC – Health Care

PART B: REIMBURSEMENT INFORMATION FOR OVER-THE-COUNTER MEDICATIONS

In order to substantiate the purchase of an over-the-counter medication, you must provide the Plan Administrator with a store receipt showing (1) the name of the medication, (2) the date of purchase, and (3) the price paid. You also need to explain who utilized, or will utilize, the medication and the specific illness or injury for which the medication was or will be used. Please remember that you cannot be reimbursed for dietary supplements, e.g. vitamins, or other over-the-counter medications that are merely beneficial for general health and are not prescribed by a physician.

	Name of Over- The-Counter Medication	Purchase Date (MM/DD/YY)	User of Medication/Relationship to Participant	Specific Illness or Injury For Which Medication Used or Will Be Used	Amount for which You are Requesting Reimbursement
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

Part B Total Reimbursement Request Amount \$ _____

Total Reimbursement Request Amount (Parts A and B) \$ _____

*Expense Codes: HC – Health Care

PART C: FOR YOUR SIGNATURE

I request reimbursement for the expenses itemized above.

Certification

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:

- They were incurred for services or supplies received by me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered.

I further certify that I have not deducted nor will deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account. I understand that reimbursement will be made in accordance with the provisions of the Health Care Spending Plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

WAUSAU BENEFITS shall not be liable for any penalties or damages as a result of an inappropriate claim being filed by me.

Employee Signature _____ Date _____

PART D: Eligibility Information

1. You may be reimbursed for certain health care expenses which (a) would otherwise be a deductible item on your Federal income tax return, or (b) expenses you incur for over-the-counter medicines and drugs used to alleviate or treat personal injuries or sickness.
2. You may receive up to the amount you have agreed to contribute for the current year by supplying the necessary documentation verifying the claim. This documentation could include a bill or receipt from a medical provider or an Explanation of Benefits from an insurance company describing the outstanding balance being claimed. **In order to substantiate the purchase of an over-the-counter medication, you must provide the Plan Administrator with a store receipt showing (1) the name of the medication, (2) the date of purchase, and (3) the price paid. You also need to explain who utilized, or will utilize, the medication and the specific illness or injury for which the medication was or will be used.**
3. The expense being claimed may not be reimbursed from any other sources or deducted on your personal income tax.
4. Examples of eligible expenses are: medical plan deductibles and co-payments, amounts over usual and customary allowance, dental care expenses and orthodontic, routine physicals, hearing exams and hearing aids, vision exams, eye glasses, contact lenses, over-the-counter medications such as antacids, allergy medicine, pain relievers, and cold medicines, travel expenses primarily for and essential to health care and health care associated with adoption. All such expenses must have been incurred during the plan year and the grace period of the first 2 ½ months of the following plan year.
5. Expenses covered by a health benefit plan or other available medical plan, should be filed as a claim under such plan prior to being submitted as a Spending Account claim.
6. Payments for orthodontic services may be submitted monthly after payment is made to the provider. Use the date of payment for the "Service Date."
7. All other health care expenses which have not been processed under the provisions of a health benefit plan should be supported by bills which state:
 - provider of service (name and address)
 - person receiving service
 - type of service or supply
 - amount of charge for service or supply
 - date of service
8. If your claim includes over-the-counter medication, you must provide a receipt containing the following information for each purchase for which you desire reimbursement:
 - the date of the purchase
 - the amount
 - the name of the product

You cannot be reimbursed for dietary supplements or other over-the-counter medications that are merely beneficial for general health.

9. If your claim includes travel expenses associated with health care, record your computation of mileage for your records. Travel mileage to obtain health care must meet IRS regulations. You may deduct out-of-pocket expenses for your car as specified by the IRS or use the IRS annual standard mileage rate. Add parking and tolls to the amount you claim under either method. You must provide the following information for each travel expense for which you desire reimbursement:
 - the date of the appointment
 - whose (*i.e.*, participant, spouse or dependent) appointment it was
 - the name and address of the physician/hospital, etc.
 - the distance traveled

Refer to IRS Publication 502 for detailed information on eligible health care expenses. You can obtain this publication via the IRS internet site at <http://www.irs.ustreas.gov/formspubs/index.html> or by calling the IRS at 1-800-TAX-FORM.

Expenses for Services or Supplies must, however, be incurred in the plan year and the grace period of the first 2 ½ months of the following plan year, and while you are participating in the Health Care Spending Plan.