SelectAccount℠
FAMILY *of* PRODUCTS

MEDICAL EXPENSE REIMBURSEMENT ACCOUNT CLAIM FORM

☐ ✔ if this is a resubmission ☐ ✔ if new address

Use this form for eligible expenses incurred by you or your eligible dependents.

Complete when faxing: # of pages _____

To expedite reimbursement, fax this form and supporting documentation to 1-866-231-0214. This form serves as as the cover page.

SECTION A – Account Holder Information (PLEASE PRINT)

ACCOUNT HOLDER'S NAME LAST	FIRST	MIDDLE	SELECTACCOUNT ID#
			S A
STREET ADDRESS			SOCIAL SECURITY # (if SA# not known)
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER / EMPLOYEE ID # (if applicable)
		-	( ) -
EMPLOYER'S NAME			

SECTION B – Claim Detail (PLEASE PRINT)

* Required information - if information is missing, the processing of your claim may be delayed.

*Date(s) of Service	*Name of Person Receiving Service	*Name of Provider of Service	*Type of Service/ Supply Provided	*Reimbursement Requested
/ / to / /				$
/ / to / /				$
/ / to / /				$
/ / to / /				$
/ / to / /				$
/ / to / /				$
			*TOTAL	$

SECTION C – Account Holder Signature

I authorize the above expenses to be reimbursed from my health FSA account or VEBA. To the best of my knowledge, my statements in this form are true and complete. I certify all of the following: Either I, my Spouse, or my Dependent has received the services described above on the dates indicated and the expenses qualify as valid Medical Care Expense under Code 213(d). These expenses have not previously been reimbursed under the FSA, VEBA or any other plan, and I will not seek reimbursement for them under the medical plan or any other health plan. These expenses are for medical care excluding cosmetic purposes, and are not incurred for general health purposes, and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me).

ACCOUNT HOLDER SIGNATURE	DATE

RETURN THIS FORM TO:

SelectAccount
P.O. Box 64193
St. Paul, MN 55164-0193
FAX: (651) 662-7247
(866) 231-0214

FORMS AVAILABLE:
www.selectaccount.com
or by calling
SelectAccount Customer Service

CUSTOMER SERVICE:
(651) 662-5065
(800) 859-2144

HOW TO FILE A CLAIM

To receive reimbursement for eligible expenses, fax **OR** mail (not both) a completed claim form along with IRS-required documentation. To expedite your request, fax your claim form and supporting documentation. If the expense incurred is reimbursable by an insurance company, you must submit the expense to the insurance company first. You can then use the Explanation of Benefits (EOB) received from the insurance company as your expense documentation. The EOB you receive from your insurance company is the best source of expense documentation for use in submitting your claims. **Documentation of the expense must include all of the following:**

- date of service
- name of person receiving service
- name of provider of service
- type of service/supply provided
- amount charged for each service/supply or the amount not reimbursed by insurance

***CANCELLED CHECKS DO NOT QUALIFY AS THIRD-PARTY DOCUMENTATION AND ARE NOT ACCEPTED BY THE IRS.**

Be sure to provide all information requested on the form. If the form is incomplete or unsigned, your claim request will be delayed. Please do not use a highlighter on this form or claim documentation. Instead, circle and add notations with a dark pen as needed.

Fax Tips

✔ Complete claim form using a dark pen (do not use a pencil).
✔ If your documentation is printed on dark paper, copy it onto lighter paper.
✔ Do not mail originals.
✔ Confirm successful transmission.

Mailing Tips

✔ Do not staple.
✔ Neatly tape any small receipts onto an 8.5 x 11 sheet of paper.

COMPLAINT/APPEAL INFORMATION

The Payment Activity Report you receive by mail will explain how your claim was processed based upon the information submitted to us. You or your designated representative may appeal a denial, partial denial, or reduction of your claim by following our complaint procedures. First, contact customer service for an explanation. If you are not satisfied with the explanation given, we will send you a form to file your complaint. You may also submit any documents, records, or other information that relates to your claim for benefits. Upon receipt of your request, we will provide a full and fair review of your complaint and a written notice of our decision according to the timeframe found in your Plan documentation.

If you are a member of a group plan that is subject to the Employee Retirement Income Security Act (ERISA), once you have exhausted our complaint/appeal process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.