HealthEquity® | WageWorks

www.healthequity.com/wageworks

HEALTH REIMBURSEMENT ACCOUNT
How to File a Claim for Approval

Claim Filing Options:

- **File claim online:** Log in to your account at **www.healthequity.com/wageworks** to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 877-353-9236 , **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

- Complete ALL account holder information.
- Provide your employer name without abbreviation.
- Use your documentation to complete each section of the form, including the following:
  - Provider Name
  - Service Date(s)
  - Patient Name and Relationship to Account Holder
  - Type of Service
  - Patient Responsibility
  - Provider Signature is not required, but can replace need for other proof of service

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Tip For Claim Submission

- For a complete list of eligible expenses specific to your plan, log in to your account at **www.healthequity.com/wageworks** and select "Eligible Expense" from the left side of the screen. Only submit claims for eligible expenses.

Tips For Documentation

- Ensure that the documentation is legible.
- Review your plan's FAQs document to confirm the documentation requirements for claims submission. Failure to submit the required documentation may result in a delay in processing your claim.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log in to your account at **www.healthequity.com/wageworks** and select "Profile" in the upper right corner of the screen).

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HEALTH REIMBURSEMENT ACCOUNT (HRA)
Retiree Only Pay Me Back Claim Form

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at **www.healthequity.com/wageworks** to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: **Fax:** 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging in to your account at **www.healthequity.com/wageworks**.

ACCOUNT HOLDER:

Last Name

First Name

ID Code*

Account Holder Zip Code

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

Employer Name

ELIGIBLE EXPENSES

See full list of all eligible standard section 213(d) expenses covered under the Health Reimbursement Account on the participant website under "Eligible Expenses List" section.

CLAIMS FOR OUT-OF-POCKET EXPENSES

For non-premium items, you must attach the itemized pages of your Explanation of Benefits (EOB); the summary page is not sufficient for reimbursement. For premium reimbursement, attach proof of coverage/proof of post-tax payment.

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider (Replaces the need for other proof of service. Not allowable for Premium reimbursements.):		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Other: _____ ☐ Qualifying Child ☐ Qualifying Relative Type of Service: ☐ Premiums ☐ RX ☐ Dental/Orthodontia ☐ Vision	$
PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider (Replaces the need for other proof of service. Not allowable for Premium reimbursements.):		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Other: _____ ☐ Qualifying Child ☐ Qualifying Relative Type of Service: ☐ Premiums ☐ RX ☐ Dental/Orthodontia ☐ Vision	$
PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider (Replaces the need for other proof of service. Not allowable for Premium reimbursements.):		Patient Name: _____ Relationship to Account Holder: ☐ Self ☐ Spouse ☐ Other: _____ ☐ Qualifying Child ☐ Qualifying Relative Type of Service: ☐ Premiums ☐ RX ☐ Dental/Orthodontia ☐ Vision	$

CLAIM FORM TOTAL: $ 0

CERTIFICATION AND AUTHORIZATION: I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible 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 confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (click on LOG IN/REGISTER) or the HealthEquity User Agreement at www.healthequity.com.