Health**Equity** 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

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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ACCOUNT HOLDER:

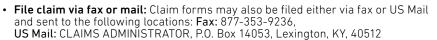
Last Name

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

* 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

www.healtheguity.com/wageworks

• 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.





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.

| ID Code* Accou | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | out your it | o couc. | | | | | | | | | | | | | |
|--|---|---|---|--|--------------------|-------------------|-----------------|-------------------|--------------------------------|-----------------|--------|---------|-----------------------|-----------------------|-------|-------|--|
| | | | | | | | | | | | | | | | | | |
| Employer Name | | | · · · · · · · · · · · · · · · · · · · | | | l | | | | • | | | | | • | | |
| ELIGIBLE EXPENSES See full list of all eligible stand under "Eligible Expenses List" | lard section 2 section. | 13(d) exp | enses cov | vered und | ler the l | Health | Reim | burse | ement . | Acco | unt oı | n the p | partici | pant w | ebsit | te | |
| CLAIMS FOR OUT-OF-POCK For non-premium items, you n reimbursement. For premium | nust attach th | ne itemize | ed pages h proof o | of your E f coverag | xplanat je/proo | ion of f of po | Benet st-tax | fits (E : payr | OB); th | ne su | mma | ry pag | je is n | ot suff | icien | t for | |
| PROVIDER NAME | SERVICE I (Start and En (MM/DD) | nd Dates) | PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE | | | | | | | | | | OUT-OF-POCKET COST | | | | |
| Signature of Provider (Replaces th service. Not allowable for Premium re | Patient Name: Relationship to Account Holder: Self Qualifying Child Premiums Spouse Qualifying Relative RX Other: Dental/Orthodontia | | | | | | | | | \$ | | | | | | | |
| PROVIDER NAME | SERVICE I (Start and En (MM/DD/ | nd Dates) | PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE | | | | | | | | | | OUT-OF-POCKET COST | | | | |
| Signature of Provider (Replaces the service. Not allowable for Premium re | | | -1 | e 🗆 Qu | | hild | | [] [| Type of S Prem RX Denta Vision | iums al/Orth | | - 1 | \$ | | | | |
| PROVIDER NAME | SERVICE I (Start and En (MM/DD) | nd Dates) | 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 Qualifying Child Premiums Spouse Qualifying Relative RX Other: Dental/Orthodontia | | | | | | | | \$ | | | | | |
| | | | | | | | | CLAI | M FO | RM | тот | AL: | \$ | | | | |

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.