HealthPartners®

Health Care Claim Form

(For use with HRA, FSA and PCA spending accounts)

Employee Information (PLEASE PRINT)

Employee Last Name | First Name | Middle

Social Security Number

Employer's Name | Employee ID # (if applicable)

E-mail Address ☐ I would like an e-mail confirming this claim has been received | Daytime Phone Number

For address changes, please contact your HR department.

Some of these claims have been previously submitted. ☐ Yes ☐ No

☐ I have completed an automatic claims submission opt-out form. ☐ I approve the use of any PCA funds.

(PLEASE PRINT) Use one line for each receipt. Do not combine two or more receipts on one line. Use additional forms if necessary.

Date(s) Service was incurred From	Through	Name of Person Receiving Service	Name of Provider of Service	Description of Service/Supply	Is any portion of Service Covered by Insurance?	Amount Requested for Reimbursement
					Yes ☐ No ☐	$
					Yes ☐ No ☐	$
					Yes ☐ No ☐	$
					Yes ☐ No ☐	$
					Yes ☐ No ☐	$
					Yes ☐ No ☐	$
				Total Reimbursement Requested		**$**

Employee Certification

I hereby certify that the above information is correct; I have not received reimbursement previously for these expenses from any other plan. I have read the printed materials I have received describing this plan; I will retain a copy of this form and all original receipts for my records; and I am responsible for compliance with all applicable administrative processes; tax regulations and documentation. I understand that it is my responsibility to return any duplicate reimbursement received from any other sources to my account; I am responsible for any and all bank, savings or checking account charges that I incur; and that healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

Employee Signature | Date

Mail this form and supporting documentation to:
HealthPartners Service Center
CDHP - Mail Route 21104T
P.O. Box 297
Minneapolis, MN 55440-0297

Or Fax to: **952-883-5026, 1-877-624-2287**

Questions: **Metro Area: 952-883-7000**
Outside metro: 1-866-443-9352
TTY line: 952-883-5127
www.healthpartners.com

Please retain a copy of this form and all attachments for your records.

Healthcare Claim Reimbursement Instructions

Healthcare Expenses
Healthcare expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. Expenses for solely cosmetic reasons or for general health and well-being generally are not eligible expenses for medical care.

Recurring claims
Submit a claim form with supporting payment plan documentation from the service provider (for example, an orthodontia payment plan). This eliminates the need to send in a claim form for each payment. Recurring claims are processed once a month.

Supporting third party documentation for healthcare expenses must include at least one of the following:

- Explanation of Benefits (EOB) – the statement you receive each time a claim is submitted to your health, dental or vision plan
- Itemized statement or receipt containing:
  - the type of service or product provided, (including prescription name);
  - the date the expense was incurred;
  - the name of the employee or dependent for whom the service or product was provided;
  - the person or organization providing the service or product; and
  - the amount of the expense after insurance.
- Payment plan for regular payments such as an orthodontia payment plan (see separate orthodontia document)

Documentation that **will not** be accepted to substantiate reimbursement includes, but is not limited to:

- Credit card receipts
- Cancelled checks
- Billing statement showing “previous balance”, “balance forward”, or “received on account”

For potentially qualifying expenses where a physician note is required (e.g., massage therapy, hormone replacement therapy, nutritional supplements, etc.), the documentation requirements have increased. To meet tighter federal regulations, HealthPartners FSA now requires a Medical Necessity Form completed by a physician. You can find the Medical Necessity Form on **healthpartners.com**.

Before submitting your healthcare reimbursement claim form
Expedite your claim by avoiding these common mistakes:

1. Be sure to sign and date the claim form.
2. Include the appropriate documentation, including the EOB whenever possible, to substantiate your expenses. If multiple items are on a receipt, circle the items for reimbursement (do not highlight the items).
3. Complete the claim form in full. Be sure that the supporting documentation equals the total you are requesting for reimbursement.
4. Please be sure to keep a copy of your claim form; original receipts should not be sent but kept for your records.

If you are unsure if a medical expense is eligible for reimbursement, please call HealthPartners Member Services at 952-883-7000, toll-free at 866-443-9352 or 952-883-5127 TTY, or log on to your member home page at **healthpartners.com** to view the EBIA eligible expense table provided.