SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS FAMILY HEALTH PLAN

Health Reimbursement Claim Form

Name: _____
Last First Middle Initial

Social Security Number: _____ Date of Birth: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____
Street City State Zip

Please attach an **Explanation of Benefits (EOB)** statement that shows the patient's name; and the co-pay, co-insurance, or deductibles paid under our Plan or your spouse's employer-sponsored health insurance plan (**Please No credit card receipts or copied checks).** In the case of a prescription reimbursement request, attach the pharmacy's drug receipt. These documents must show the name and contact information of the service provider. For reimbursement of health insurance contributions for your spouse's employer-sponsored health plan (including dental and vision), you must attach a copy of your spouse's payroll stub which shows the deduction for insurance as an **"After-Tax" deduction**, along with a written confirmation from your spouse's Plan Administrator stating that his/her coverage complies with ACA ("Affordable Care Act") Regulations, prior to approving such reimbursement request.

PATIENT NAME	DATE(S) OF SERVICE	BRIEF DESCRIPTION	REIMBURSEMENT REQUESTED
			$
			$
			$
			$
			$
			$
			$
			$
		(Total from Additional Sheet if Necessary)	$

Total Reimbursement Requested $ _____

I certify that my statements on this Health Reimbursement Claim Form and associated documentation are complete and true. I am claiming reimbursement only for eligible expenses incurred by me or my eligible dependents and subject to the Plan's rules. I also certify that these expenses have not been, nor will be in the future, paid or reimbursed by this Plan or any other benefit plan. Additionally, I authorize my Premium Credit Account to be reduced by any allowed reimbursement amount plus a processing fee of **$20** per reimbursement check. Eligible expenses incurred in a given calendar year must be submitted for reimbursement and received by the Plan Administrator **no later than June 30th** of the following year.

Member Signature: _____ **Date:** _____

Please remember to:

- **Provide the required documentation for each expense submitted**
- **Attach an additional form if more space is needed**
- **Sign and date this Health Reimbursement Claim Form**
- **Contact the Plan Administrator at 952-854-0795 with any questions**
- **You can fax (651-776-9973), email (SCMNEW@wilson-mcshane.com) or mail your completed Health Reimbursement Claim Form to:**

South Central Minnesota Electrical Workers Family Health Plan-HRA
c/o Wilson McShane
1330 Conway St, Suite 130
St. Paul, MN 55106