

Claim Filing Options:

- **File claim online:** Log into your account at www.wageworks.com 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:

- ① Provider Name
- ② Service Date(s)
- ③ Patient Name and Relationship to Account Holder
- ④ Type of Service
- ⑤ Patient Responsibility
- ⑥ Provider Signature is not required, but can replace need for other proof of service

| ACCOUNT HOLDER: | | PATIENT | | ACCOUNT HOLDER | | OUT-OF-POCKET COST |
|--|---|---|---|----------------|--|--------------------|
| SMITH | | JOHN | | | | |
| Last Name | | First Name | | | | |
| JONES GRAPHICS | | | | | | |
| Employer Name | | | | | | |
| 5421 | 10063 | | | | | |
| ID Code* | Zip Code | | | | | |
| 1 PROVIDER NAME | 2 SERVICE DATES (Start and End Dates) (MM/DD/YYYY) | 3 RELATIONSHIP AND TYPE OF PATIENT | 4 TYPE OF SERVICE | | | 5 |
| Mercy Hospital | 010515 010515 | Patient Name: John Smith Relationship to Account Holder: <input checked="" type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: | Type of Service: <input checked="" type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Psych/Therapy <input type="radio"/> Ortho <input type="radio"/> Chiro <input type="radio"/> Co-payment <input type="radio"/> Other: <input type="radio"/> Lab <input type="radio"/> Vision <input type="radio"/> Hospital <input type="radio"/> X-Ray <input type="radio"/> OTC <input type="radio"/> Office Visit | | | \$ 25.00 |
| Signature of Provider: (Replaces the need for other proof of service.) <i>Dr. Mark Johnson, M.D.</i> | | | | | | |
| Mercy Pharmacy | 011415 011415 | Patient Name: Mary Smith Relationship to Account Holder: <input checked="" type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: | Type of Service: <input checked="" type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Psych/Therapy <input type="radio"/> Ortho <input type="radio"/> Chiro <input type="radio"/> Co-payment <input type="radio"/> Other: <input type="radio"/> Lab <input type="radio"/> Vision <input type="radio"/> Hospital <input type="radio"/> X-Ray <input type="radio"/> OTC <input type="radio"/> Office Visit | | | \$ 10.70 |
| Signature of Provider: (Replaces the need for other proof of service.) | | | | | | |

Tips For Claim Submission

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
 - A qualifying child is defined as a tax dependent child up to age 26 or any age if permanently disabled.
 - A qualifying relative is someone who resides with you for more than half of the year.
 - Qualifying children and relatives must not provide more than half of his/her own support.
- For information to claim orthodontia expenses, refer to the guide located at: <https://www.wageworks.com/employees/support-center/important-forms.aspx>.
- For a complete list of eligible expenses specific to your plan, log in to your account at www.wageworks.com and select "Eligible Expense" from the left side of the screen. Only submit claims for eligible expenses.
- A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity. Cosmetic surgery or procedures, e.g., teeth whitening, are not eligible expenses unless deemed as medically necessary by a licensed physician. A letter of medical necessity form can be obtained at: <https://www.wageworks.com/employees/support-center/important-forms.aspx>.

Tip for Over-the-Counter Expenses

- A prescription is required for any over-the-counter expense listed as "Yes (Rx)" on the eligible expense list. As a result of the Health Care Reform Law, in addition to the required detailed receipt, an actual prescription written by a doctor (on a prescription pad or form) dated on or before the date the expense was incurred is required to verify that the over-the-counter medicine is prescribed for a known medical condition.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 6 required pieces of information needed to approve your expense, and are not acceptable for submission.
- Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense.
- 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.
- Your provider may sign the form confirming the date of services, charges and other service or product information in lieu of providing separate documentation or other proof of service.

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 into your account at www.wageworks.com and select "Profile" in the upper right corner of the screen).

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log into your account at www.wageworks.com 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 into your account at www.wageworks.com.



ACCOUNT HOLDER:

| | | |
|---------------|------------|--|
| | | |
| Last Name | First Name | |
| | | |
| Employer Name | | |
| | | * 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. |
| ID Code* | Zip Code | |

| PROVIDER NAME | SERVICE DATES <small>(Start and End Dates) (MM/DD/YY)</small> | PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE | OUT-OF-POCKET COST | | | | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Signature of Provider: <small>(Replaces the need for other proof of service.)</small> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | | | | | | Patient Name: _____ Relationship to Account Holder: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____ Type of Service: <input type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Psych/Therapy <input type="radio"/> Ortho <input type="radio"/> Chiro <input type="radio"/> Co-payment <input type="radio"/> Other _____ <input type="radio"/> Lab <input type="radio"/> Vision <input type="radio"/> Hospital <input type="radio"/> X-Ray <input type="radio"/> OTC <input type="radio"/> Office Visit | \$ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Signature of Provider: <small>(Replaces the need for other proof of service.)</small> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | | | | | | Patient Name: _____ Relationship to Account Holder: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____ Type of Service: <input type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Psych/Therapy <input type="radio"/> Ortho <input type="radio"/> Chiro <input type="radio"/> Co-payment <input type="radio"/> Other _____ <input type="radio"/> Lab <input type="radio"/> Vision <input type="radio"/> Hospital <input type="radio"/> X-Ray <input type="radio"/> OTC <input type="radio"/> Office Visit | \$ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Signature of Provider: <small>(Replaces the need for other proof of service.)</small> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | | | | | | Patient Name: _____ Relationship to Account Holder: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____ Type of Service: <input type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Psych/Therapy <input type="radio"/> Ortho <input type="radio"/> Chiro <input type="radio"/> Co-payment <input type="radio"/> Other _____ <input type="radio"/> Lab <input type="radio"/> Vision <input type="radio"/> Hospital <input type="radio"/> X-Ray <input type="radio"/> OTC <input type="radio"/> Office Visit | \$ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Signature of Provider: <small>(Replaces the need for other proof of service.)</small> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | | | | | | Patient Name: _____ Relationship to Account Holder: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Qualifying Child <input type="radio"/> Qualifying Relative <input type="radio"/> Other: _____ Type of Service: <input type="radio"/> Rx <input type="radio"/> Dental <input type="radio"/> Psych/Therapy <input type="radio"/> Ortho <input type="radio"/> Chiro <input type="radio"/> Co-payment <input type="radio"/> Other _____ <input type="radio"/> Lab <input type="radio"/> Vision <input type="radio"/> Hospital <input type="radio"/> X-Ray <input type="radio"/> OTC <input type="radio"/> Office Visit | \$ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| More expenses? Please complete another form. | | | CLAIM FORM TOTAL: \$ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |