

**ProcessWorks, Inc.**  
**Flexible Spending Account - Medical Expense / HRA Claim Form**

Claim Form for medical, dental, orthodontia, vision, prescription and, if applicable, eligible Health Reimbursement Arrangement (HRA) expenses.

To expedite your reimbursement, fax this Claim Form and supporting documentation toll-free to 1-800-760-3727. This Claim Form serves as the cover page.

**Complete when faxing:**

# of pages \_\_\_\_\_

Daytime e-mail or phone # \_\_\_\_\_

**1. General Claim Information (Also complete sections 2 and 3 below)**

This claim is a (fill-in one)     New Claim     Resubmission     eClaim Documentation     Debit Card Documentation

Employee Soc Sec / ID: \_\_\_\_\_

**TOTAL REQUESTED REIMBURSEMENT AMOUNT**

Employee Signature: \_\_\_\_\_

\$ \_\_\_\_\_

MED/HRA Claim

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I certify that I have not been reimbursed for these expenses from this Plan, nor have they or will they be reimbursed by any other source. I further certify that the information I provide on this form is correct and that I have read and agree to the Additional Employee Certification items listed on the back of this Claim Form.

**2. Participant Information (please print)**

\_\_\_\_\_  
**Last Name                      First Name                      MI                      Employer**

\_\_\_\_\_  
**E-mail Address**                      *Providing your e-mail address will help us communicate with you easier. ProcessWorks will not share, rent or trade your e-mail address.*

**3. Expense Information (please print)**

Complete the following information for each claim expense item. If you have multiple items of similar Types of Service (for example, ten prescriptions), you may combine them on one line. Attach supporting documentation verifying each expense. The documentation must list the date that the service was performed, provider name, type of service, patient name, and your portion of the charge for the service.

	Dates of Service	Provider Name / Type of Service	Amount
1.	____/____/____ to ____/____/____	_____	\$ _____
2.	____/____/____ to ____/____/____	_____	\$ _____
3.	____/____/____ to ____/____/____	_____	\$ _____
4.	____/____/____ to ____/____/____	_____	\$ _____
5.	____/____/____ to ____/____/____	_____	\$ _____
6.	____/____/____ to ____/____/____	_____	\$ _____
7.	____/____/____ to ____/____/____	_____	\$ _____
8.	____/____/____ to ____/____/____	_____	\$ _____

**4. Submitting Your Claim**

You must complete sections 1, 2 and 3 above. Review back of form for helpful **Faxing and Mailing Tips** and other important information on how to successfully file a claim. Failure to complete all sections of this form or to attach sufficient claim documentation will delay your reimbursement. Keep copies of your claim. If you require a copy of a submitted claim from ProcessWorks, a \$25 fee may apply.

**Send Claim Form and supporting expense documentation to ProcessWorks, Inc.:**

**Toll-Free Claims Fax:** 1-800-760-3727 (Claim Form serves as the cover page)

**Mailing Address:** P.O. Box 2490, Brookfield, WI 53008-2490



**ProcessWorks INC.**  
 the right source to outsource™

©2005 ProcessWorks, Inc.

**Questions? Visit ProcessWorks on the web or call 1-888-868-2492  
 (262-827-7030 Milwaukee metro area)**

To submit your claim online, view complete account history, review list of eligible expenses, obtain additional forms, and other helpful information visit

[www.myprocessworks.com](http://www.myprocessworks.com)

10000



**Important Claims Submission Information**  
**Please Do NOT Fax or Mail This Page**

**Definition of "Incurred"**

The term "incurred" used throughout this form refers to the date you or your eligible dependent is provided the care that gives rise to the medical, dental, vision, prescription, or other qualifying expense. This date could be different than the date you are billed or pay for the expense. By IRS regulations, the date the service is incurred determines the plan year in which it is considered for reimbursement.

**Additional Employee Certification**

I certify the expenses for which I am claiming:

- ◆ Were incurred by me or my eligible dependents (spouse is considered a dependent) during a plan year in which I and/or my dependent(s) were covered under this Plan.
- ◆ If over-the-counter medication or drugs; 1) were incurred solely to alleviate or treat personal injury or sickness, and 2) the quantity purchased is reasonably able to be consumed during the plan year in which it was incurred.
- ◆ Will not be claimed as a deduction or credit on any personal income tax return.
- ◆ Are eligible according to the terms of the Plan. If I've received a reimbursement for expenses later found ineligible, I will be responsible for taxes or penalties arising from the ineligible expenses.
- ◆ I understand that ProcessWorks may scan my claim and expense documentation and store them as digital images. My original claim and expense documentation may be destroyed by ProcessWorks within a reasonable time period after receipt.
- ◆ **Health Savings Account (HSA) Owners** – I understand that if I participate in both the Health Savings Account (HSA) and the Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA), medical expenses for the FSA and HRA Plan are limited to dental, vision, and expenses incurred after the deductible is met under the high deductible health insurance plan. I certify the expenses I am claiming do not apply towards the deductible of my high deductible health insurance plan. I understand that if I am claiming medical expenses incurred after my medical deductible that I will attach an Explanation of Benefits from my insurance carrier that shows the medical deductible has been met.

**Faxing and Mailing Tips**

To receive the fastest possible reimbursement, submit your claim online at [www.myprocessworks.com](http://www.myprocessworks.com). If you do not have internet access you can submit your claim for FREE using our toll-free fax line. You can also mail your claim; however, you may experience slower reimbursements due to mailing delays. Faxed or mailed claims require up to two business days for review.

**Please do not use a highlighter on this form or claim documentation. Instead, circle and add notations with a dark pen as needed.**

**Fax Tips – Submit your claim for free via toll-free fax**

- ✓ Complete claim form using a dark pen (do not use a pencil).
- ✓ If your documentation is printed on dark paper, copy it onto lighter paper.
- ✓ **Do not mail originals.**

**Mailing Tips**

- ✓ **Do not staple.**
- ✓ Neatly tape any small receipts onto an 8 ½" by 11" sheet of paper.

Faxed or mailed claims cannot be verified until up to two business days after receiving your faxed or mailed claims. To receive automatic notification of received claims and/or payments via e-mail, sign up for *eStatus Alerts* at [www.myprocessworks.com](http://www.myprocessworks.com).

**Helpful Hints on How to Successfully File a Claim**

- ✓ Documentation must clearly list the date the service was incurred, provider name, type of service, patient name, and your portion of the service provided.
- ✓ If the expense incurred is reimbursable by an insurance company, you must submit the expense to the insurance company first. You can then use the Explanation of Benefits (EOB) received from the insurance company as your expense documentation. **The EOB you receive from your insurance company is the best source of expense documentation for use in submitting your claims.**
- ✓ **Canceled checks, 'balance forward' statements, 'previous balance' statements, 'paid on account' statements or receipts, charge card receipts, or charge card statements are not acceptable forms of expense documentation according to the IRS as they do not clearly indicate the date of service or type of service.**
- ✓ For prescription expenses, submit the prescription receipt you received with the medication purchased showing the patient name, medication name, the date the prescription was filled, and the amount you owe for the medication. **Cash register receipts or charge slips for prescription purchases cannot be accepted as they do not indicate the medication name or patient.**
- ✓ For over-the-counter medications, submit an original cash register receipt that **clearly** indicates the item name (such as cold medicine, antacid, allergy medicine, or pain reliever), date, and cost of the item purchased. According to the IRS, handwriting the required information on the receipt or attaching box tops or other product information to the receipt is NOT acceptable. Insufficiently documented claims are not eligible for reimbursement.
- ✓ Claims incurred during the plan year may be submitted at any time throughout the plan year or during the "run-off period". The run-off period is the additional length of the time following the end of the plan year to submit claims. Your plan may also allow a "grace period". The grace period is the additional time to incur expenses after the plan year ends. Claims incurred during the grace period will be paid from any remaining balance you have from the preceding plan year before being reimbursed from the current plan year. Check your Summary Plan Description (SPD) or with your Human Resource Department to see if the grace period is available to you.
- ✓ All expenses must be incurred prior to being considered for reimbursement. If the expense has not been incurred it is not eligible for reimbursement.
- ✓ Keep copies of your claim. You can submit *legible* photocopies of your expense documentation to ProcessWorks. If you require a copy of a submitted claim from ProcessWorks, a \$25 fee will apply.

**Some Expenses that are NOT Eligible For Reimbursement**

- |  |   |
|--|---|
| ◆ Dietary supplements or vitamins for general well-being           | ◆ Marital or family counseling                |
| ◆ Teeth bleaching or whitening                                     | ◆ Cosmetic surgery                            |
| ◆ Birthing classes   | ◆ Rogaine or other hair growth medications    |
| ◆ Athletic or health club memberships                              | ◆ Illegal operations or treatments            |
| ◆ Insurance premiums unless specifically included in your HRA plan | ◆ Weight loss programs for general well-being |

**Definitions**

**Dates of Service** – The date the service was incurred. This date could be different than the date you are billed or the date you pay for the expense. Prescription drugs are based on the date the prescription is filled and eyeglass/contact lens purchases are based on the date ordered. These dates could be different than the date picked up or the date paid.

**Provider Name / Type of Service** – Doctor name, store name, dentist, clinic, hospital, etc. along with what service was performed (for example, 'Dr. Smith / Office visit', 'ABC Drug Store / Prescriptions', or 'The Vision Store / Contacts').

**Amount Requested** – The amount of the expense you are responsible for paying.

**Total Requested Reimbursement Amount** – The total of all **Amount Requested** expense line items.



ProcessWorks, Inc.  
P.O. Box 2490  
Brookfield, WI 53008-2490

Toll-Free Claims Fax: 1-800-760-3727 (262-879-0016 in Milwaukee metro area)  
24 Hour Access: 1-888-868-2492 (262-827-7030 in Milwaukee metro area)  
[www.myprocessworks.com](http://www.myprocessworks.com)