BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

REQUEST FOR REIMBURSEMENT PREFERRED HEALTH FSA/HRA

Attach a copy of the itemized bill and an Explanation of Benefits (EOB) (if applicable) along with proof of payment. All documentation must include the patient name, description of service provided, date provided, and the charge. Be sure to sign and date this form before sending it with all attachments to the address shown.

I certify that the attached expenses are eligible for reimbursement from my designated Health FSA/HRA and that they qualify as deductions as outlined by the U. S. Internal Revenue Code or by my employer. I request reimbursement up to the limit allowed in my account. I further certify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan. A dependent must be considered an eligible dependent under the applicable provisions of section 105 and 106 of the U.S. Internal Revenue Code.

Signature of Employee	Date
	___ / ___ / _____

Blue Cross and Blue Shield of Alabama
Preferred Blue Accounts
P.O. Box 11586
Birmingham, Alabama 35202-1586
1-800-213-7930
Toll Free Fax 1-877-889-3610

Visit our web site **www.bcbsal.com** for detailed account information

Important: This form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from a tax-deferred, employee-funded spending account established by your employer under Section 125 of the U.S. Internal Revenue Code or from your HRA established by your employer. Payments from such an account may only be made for qualified expenses on behalf of qualified dependents when such expenses have not been reimbursed and are not reimbursable by any other benefit plan.

SECTION 1: EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME

DATE OF BIRTH	PREFERRED BLUE ACCOUNT NUMBER
___ / ___ / _____	___ – ________

NOTE: Your Preferred Blue Account number is your Blue Cross and Blue Shield of Alabama contract number. If you do not have your account number, please contact Customer Service at 1-800-213-7930.

COMPANY NAME	WORK PHONE (Please include area code)	HOME PHONE (Please include area code)
	( ) ___ – ____	( ) ___ – ____

SECTION 2: HEALTH FSA/HRA REIMBURSEMENT INFORMATION

In order to be properly reimbursed, complete this section for each eligible expense and attach all necessary itemized receipts. (PLEASE DO NOT HIGHLIGHT ITEMS ON YOUR RECEIPTS.)

TYPE SERVICE
- ☐ MEDICAL
- ☐ VISION
- ☐ DENTAL
- ☐ ORTHODONTICS
- ☐ RX/OTC
- ☐ PREMIUM*
- ☐ OTHER

PATIENT'S FIRST NAME	LAST NAME	
RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT	COVERED BY INSURANCE ☐ YES ☐ NO	**AMOUNT**
DATE OF BIRTH ___ / ___ / _____	DATE OF SERVICE ___ / ___ / _____	
TYPE CHARGE ☐ COPAY ☐ DEDUCTIBLE ☐ COINSURANCE ☐ OTHER	DOCUMENTATION ATTACHED ☐ YES ☐ NO	____ • __

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- ☐ VISION
- ☐ DENTAL
- ☐ ORTHODONTICS
- ☐ RX/OTC
- ☐ OTHER

PATIENT'S FIRST NAME	LAST NAME	
RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT	COVERED BY INSURANCE ☐ YES ☐ NO	**AMOUNT**
DATE OF BIRTH ___ / ___ / _____	DATE OF SERVICE ___ / ___ / _____	
TYPE CHARGE ☐ COPAY ☐ DEDUCTIBLE ☐ COINSURANCE ☐ OTHER	DOCUMENTATION ATTACHED ☐ YES ☐ NO	____ • __

TYPE SERVICE
- ☐ MEDICAL
- ☐ VISION
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PATIENT'S FIRST NAME	LAST NAME	
RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT	COVERED BY INSURANCE ☐ YES ☐ NO	**AMOUNT**
DATE OF BIRTH ___ / ___ / _____	DATE OF SERVICE ___ / ___ / _____	
TYPE CHARGE ☐ COPAY ☐ DEDUCTIBLE ☐ COINSURANCE ☐ OTHER	DOCUMENTATION ATTACHED ☐ YES ☐ NO	____ • __

TYPE SERVICE
- ☐ MEDICAL
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- ☐ DENTAL
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PATIENT'S FIRST NAME	LAST NAME	
RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT	COVERED BY INSURANCE ☐ YES ☐ NO	**AMOUNT**
DATE OF BIRTH ___ / ___ / _____	DATE OF SERVICE ___ / ___ / _____	
TYPE CHARGE ☐ COPAY ☐ DEDUCTIBLE ☐ COINSURANCE ☐ OTHER	DOCUMENTATION ATTACHED ☐ YES ☐ NO	____ • __

*The premium reimbursement is available to select HRA plans only.

TOTAL ____ • __

Helpful Tips for Successfully Filing a Request for Reimbursement.

1. Complete your Request for Reimbursement Form neatly.

If your form can not be read properly, it cannot be processed accurately.

- Do not highlight receipt items. Circle them instead.
  (High-lighter when faxed or scanned can appear as black or gray)
- Only submit expenses for an eligible dependent. An eligible dependent must meet the provisions of sections 105 and 106 of the U. S. Internal Revenue Code.

2. Provide appropriate supporting documentation.

IRS rules state that you must provide appropriate documentation.

- Documentation for an eligible healthcare expense must show:
  - The date of service (the date you incurred the expense)
  - The name of the service provider
  - To whom the service was provided (patient's name)
  - The out of pocket expense (amount you paid for the service)
  - A clear and detailed service/procedure description

- Documentation for an eligible premium payment must show:
  - The name and address of the company to whom the premium payment was made
  - The policy number of your insurance
  - A list of those covered under the policy
  - The date of the premium payment
  - The time period the premium payment covered

What is acceptable documentation?

Examples of proper documentation are:

- An Explanation of Benefits (EOB) from your insurance carrier showing the above information. If the EOB indicates the procedure is not covered by your health insurance plan, you may be required to submit an itemized statement from the provider.

- For premium payments, a premium notice with proof of payment or check stub showing the premium deduction.

- For prescription drugs, a pharmacy statement including the name of the pharmacy, patient's name, date the RX was filed, patient's cost, RX number and name of the drug.

- Over-the-counter (OTC) medications and other "dual purpose" items will not be reimbursed without a written doctor's prescription. You must also include an itemized receipt indicating the item purchased.

Unacceptable documentation for healthcare expenses:

Bank card statements, credit card receipts, canceled checks, estimates of expenses, account balance statements and balance forward statements are not valid documentation.

3. Sign your form.

An unsigned form will stop your reimbursement!

4. Submit your form.

Completed forms can be submitted on our website at **www.bcbsal.com**, with the **Alabama Blue** mobile app on your smart phone, by mail, or by fax to our toll-free number.