WageWorks

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www.wageworks.com

Health Care Account

Pay Me Back Claim Form

TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40511

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Soc. Sec. # (last 4 digits)

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this page is accurate and complete. I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. I have already received these products and services and have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by my Program Sponsor and as stated on the WageWorks Web Site. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User? link).

Signature of Account Holder X _____ **Date** _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

1

- Rx
- Co-payment
- Office visit
- Other: _____
- Dental
- Over-the-counter
- Vision
- Psych / therapy
- Chiro
- Lab
- Ortho
- Hospital
- X-ray

Patient's Name

Service Start Date (MM/DD/YY)

- Self
- Spouse
- Other _____
- Child
- Relative

Relationship to Account Holder

$ _____ Out-of-Pocket Cost

2

- Rx
- Co-payment
- Office visit
- Other: _____
- Dental
- Over-the-counter
- Vision
- Psych / therapy
- Chiro
- Lab
- Ortho
- Hospital
- X-ray

Patient's Name

Service Start Date (MM/DD/YY)

- Self
- Spouse
- Other _____
- Child
- Relative

Relationship to Account Holder

$ _____ Out-of-Pocket Cost

3

- Rx
- Co-payment
- Office visit
- Other: _____
- Dental
- Over-the-counter
- Vision
- Psych / therapy
- Chiro
- Lab
- Ortho
- Hospital
- X-ray

Patient's Name

Service Start Date (MM/DD/YY)

- Self
- Spouse
- Other _____
- Child
- Relative

Relationship to Account Holder

$ _____ Out-of-Pocket Cost

4

- Rx
- Co-payment
- Office visit
- Other: _____
- Dental
- Over-the-counter
- Vision
- Psych / therapy
- Chiro
- Lab
- Ortho
- Hospital
- X-ray

Patient's Name

Service Start Date (MM/DD/YY)

- Self
- Spouse
- Other _____
- Child
- Relative

Relationship to Account Holder

$ _____ Out-of-Pocket Cost

5

- Rx
- Co-payment
- Office visit
- Other: _____
- Dental
- Over-the-counter
- Vision
- Psych / therapy
- Chiro
- Lab
- Ortho
- Hospital
- X-ray

Patient's Name

Service Start Date (MM/DD/YY)

- Self
- Spouse
- Other _____
- Child
- Relative

Relationship to Account Holder

$ _____ Out-of-Pocket Cost

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE. $ _____

MORE EXPENSES? Complete another form. QUESTIONS? See Instructions.

TOTAL THIS FORM