

Claim Form

E-mail, fax, or mail completed form and itemized verification to third-party administrator.
Instructions on reverse. Fillable version at hraveba.org.



HRA VEBA Third-party Administrator

Meritain Health | PO Box 27810 | Minneapolis, MN 55427-0810 | Phone: 1-888-659-8828 | Claim Fax: (763) 582-3470 | E-mail: myclaims@meritain.com

1. PARTICIPANT INFORMATION

Last Name _____ MI _____ First Name _____ Gender _____ **Required:** Participant Account No. or SSN _____

Date of Birth (mm/dd/yyyy) _____ Employer Name _____

Check here and complete the following only if your mailing address, phone number, and/or e-mail address has changed and needs to be updated.

Mailing Address _____ City _____ State _____ Zip _____

(_____) _____ - _____ E-mail Address (home or personal recommended) _____
 Area Code and Phone Number

2. PATIENT (COVERED INDIVIDUAL) INFORMATION (required)

NOTE: Beginning March 1, 2011, your claim will be automatically denied if you do not fully complete this section as instructed each time you file a claim. You are being asked to provide this information in accordance with federal law. Federal law requires the third-party administrator to have on file the full name, Social Security number, gender, and date of birth of all covered individuals. In addition, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires your HRA VEBA plan (the Plan) to report specific information about Medicare beneficiaries covered under the Plan. The purpose of this reporting is to assist Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees the Medicare program, coordinate the payment of benefits with other group health plans, such as your HRA VEBA plan. Federal rules determine whether Medicare or HRA VEBA should pay first.

A. This claim is for:

- Myself Qualifying child
 Spouse Qualifying relative
 Other: _____

B. If this claim is for a covered individual other than yourself, please fully complete the following:

First Name _____ M.I. _____ Last Name _____
 Date of Birth (mm/dd/yyyy) _____ Gender _____ Social Security Number _____

C. Are you separated or retired from the employer that made, or is making, contributions to this account?

No Yes - Enter your separation/retirement date here: _____, then skip to section 3.

D. Is the covered individual for this claim currently, or have they ever been, enrolled in Medicare Part A or Part B? No Yes - Complete the following:

Name (exactly as it appears on SSN or Medicare card, if available) _____ Medicare Claim Number (HICN) _____ Medicare Part A Effective Date (if applicable) _____ Medicare Part B Effective Date (if applicable) _____

3. REIMBURSEMENT REQUEST

Date service received	Service provided by	Description of service received (e.g. deductible; co-pay; out-of-pocket; prescription (Rx); dental/ortho; vision; insurance premium; etc.)	Out-of-pocket amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL for this covered individual			\$ _____

Submit additional expenses for this covered individual by attaching an itemized list. **NOTE:** If your account is allocated among multiple investment funds, withdrawals (claims) will be deducted pro rata based on your balance in each fund at the time of withdrawal unless you request otherwise.

4. PARTICIPANT SIGNATURE (required)

I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of this submitted claim to the Third-party Administrator is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized on the reverse and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by an employer and are not eligible for pre-tax deduction through a Section 125 cafeteria plan.

Have you attached itemized verification for each expense (see instructions on reverse)? Yes No

X _____
 Participant Signature

_____ Date

INSTRUCTIONS FOR SUBMITTING CLAIMS

Use this form to request reimbursement of qualified healthcare expenses and/or insurance premiums you have incurred on behalf of yourself, your spouse, and/or your eligible dependents (fillable version available at hraveba.org). Qualified expenses and premiums submitted for reimbursement must have been incurred after you became a participant eligible to file claims. Want to see your claims in progress and claims history? Go to hraveba.org and click **myHRA VEBA online** to login to your account. For more information, read **Guidelines for Submitting Claims** available online. To expedite your claim:

1. **E-mail your claim to myclaims@meritain.com and sign up for direct deposit;** its faster and more secure. Go to hraveba.org and click **myHRA VEBA online** to login to your account and sign up for direct deposit. Claims sent via **e-mail** will receive an auto-reply confirming receipt of claim. If you **fax** your claim, check the fax machine's confirmation report to confirm the transmission was successful. Claims submitted by **mail** may be viewed online after logging into your account.
2. **Fully complete each section of the claim form.** Missing information may delay the processing of your claim and could result in your claim being denied. Don't forget to sign and date the form.
3. **You must attach itemized verification for each expense or service.** Generally, verification should contain (1) patient (covered individual) name; (2) date item was purchased or service was provided; (3) description of expense or service; and (4) out-of-pocket amount. Acceptable forms of verification include (1) an explanation of benefits (EOB); (2) an itemized billing or statement from your provider; or (3) a detailed receipt for prescription or over-the-counter (OTC) medications. Cancelled checks, credit card or debit card receipts, balance forward or payment on account statements, and documentation which indicates that final insurance payment has not yet been determined are not acceptable. **NOTE: Please do not use a highlighter** on your expense receipts. If you want to identify certain items on your receipts, circle the items with a regular pen instead. Highlighting often appears illegible on faxes and electronic imaging equipment used to process your claim.
4. For qualified insurance premium reimbursement, you must attach documentation which includes the following: (1) name(s) of covered individual(s); (2) premium amount(s); (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. **NOTE: IRS regulations provide that insurance premiums paid by an employer or deducted pre-tax through a Section 125 cafeteria plan, are not eligible for reimbursement.** If you request reimbursement of premiums deducted from a paycheck, you should include a letter from the employer that confirms a pre-tax option for the deduction of such premiums is not available.

To set up systematic reimbursement of monthly insurance premiums, go to hraveba.org and click **myHRA VEBA online** to login to your account. Or, submit a completed **Systematic Premium Reimbursement Form**.

Questions? Contact the third-party administrator, Meritain Health, at myHRAVEBA@meritain.com or **1-888-659-8828**.

QUALIFIED EXPENSES AND PREMIUMS

Internal Revenue Code § 213(d) defines qualified expenses and premiums, in part, as "medical care" amounts paid for insurance or "for the diagnosis, cure, mitigation, treatment, or prevention of disease..." Expenses solely for cosmetic reasons generally are not eligible (e.g. facelifts, hair transplants, hair removal, etc.). Common expenses include co-pays, coinsurance, deductibles, and prescriptions. Common insurance premiums include medical, dental, vision, tax-qualified long-term care (subject to IRS limits), Medicare Part B, Medicare Part D, and Medicare supplement plans. Go to hraveba.org to view a more extensive list. Please note the following:

1. Qualified expenses and premiums you submit for reimbursement must be incurred after you become a claims-eligible participant.
2. If a person covered by this plan has a Section 125 healthcare flexible spending account (FSA), the FSA benefits must be exhausted before submitting eligible claims.
3. Qualified insurance premiums are reimbursable beginning with the month in which you become a claims-eligible participant.
4. **IRS regulations provide that insurance premiums paid by an employer or deducted pre-tax through a Section 125 cafeteria plan, are not eligible for reimbursement.** If you request reimbursement of premiums deducted from a paycheck, you should include a letter from the employer that confirms a pre-tax option for the deduction of such premiums is not available.
5. Systematic reimbursement of recurring qualified insurance premiums may be set up online after logging in to your account or by submitting a **Systematic Premium Reimbursement Form**.

IMPORTANT NOTICE REGARDING OVER-THE-COUNTER (OTC) DRUGS AND MEDICINES: To be eligible for reimbursement, federal healthcare reform requires that OTC medicines and drugs (except insulin) purchased on or after **January 1, 2011** be prescribed by a medical professional or accompanied by a note from a medical practitioner recommending the item to treat a specific medical condition. Thus, OTC medicines and drugs such as aspirin, antihistamines, and cough syrup must be prescribed. Eligible OTC medicines and drugs purchased on or before **December 31, 2010** remain reimbursable without a prescription. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.

QUALIFIED DEPENDENTS

Generally, dependents must satisfy the IRS definition of **Qualifying Child** or **Qualifying Relative** as of the end of the calendar year in which expenses were incurred to be eligible for benefits under your HRA plan. These requirements are defined by Internal Revenue Code § 105(b). These definitions supersede and may differ from state definitions. Go to hraveba.org for more information.

Qualifying Child. A qualifying child is an individual who is your son or daughter, stepchild, or foster child; and at the end of the calendar year in which expenses were incurred will be: (1) under age 27, or (2) permanently and totally disabled; and is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico; **OR** is a brother, sister, stepbrother, stepsister, or a descendent of your son, daughter, stepchild or foster child; and at the end of the calendar year in which expenses were incurred will be: (1) under age 19; (2) under age 24 and a full-time student; or (3) permanently and totally disabled and is younger than you; lives with you for more than half the year; does not provide more than half of his or her own support; will not file a joint tax return for the year in which the expense was incurred; and is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

Qualifying Relative. A qualifying relative is a person who is your: (1) son, daughter, stepchild, foster child, or a descendant of any of them (for example, your grandchild); (2) brother, sister, or a son or daughter of either of them; (3) father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle); (4) stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or (5) any other person (other than your spouse) who lived with you all year as a member of your household if your relationship did not violate local law; and will not be a qualifying child (see Qualifying Child above) of any other person as of the last day of the calendar year in which expenses were incurred; for whom you provided over half the support for the calendar year; has a gross income for the year of less than \$3,650; and is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

Guidelines for Submitting Claims



The below information will help you understand your HRA VEBA plan's overall claims process, including IRS documentation requirements and standard claims processing turnaround times. Knowing this information will help you submit "clean" claims that will be processed quickly and hassle-free. Please read the **Qualified Expenses and Premiums** and **Definition of Dependent** handouts available online at hraveba.org to learn more about what types of out-of-pocket healthcare expenses and premiums are eligible for reimbursement and who's covered under your HRA VEBA plan.

Where can I get a Claim Form and where do I need to send it?

Claim Forms are available online at hraveba.org or by calling the third-party administrator, Meritain Health, at **1-888-659-8828**. You can mail, fax, or e-mail your completed Claim Form to Meritain Health as indicated on the form. E-mail or fax is recommended and preferred over regular mail. A fully completed and signed Claim Form, with proper documentation attached, is required for reimbursement.

NOTE: Beginning March 1, 2011, claims received on outdated Claim Forms will be denied and will need to be resubmitted using the updated Claim Form. Always go online or request Claim Forms from the third-party administrator to make sure you're using the most current version.

What type of documentation do I need to include?

IRS rules require that you include proper documentation for each expense when submitting claims. When claims are denied, it's usually because the participant didn't submit proper documentation. You can help avoid denied claims by making sure the documentation you submit is legible and contains all four of the following basic information requirements:

1. **Name** of patient or covered individual;
2. **Date** item was purchased or service was provided;
3. **Description** of expense or service; and
4. **Amount** of out-of-pocket expense.

Generally, all of the basic information requirements are contained on any one of the following types of documents:

1. **Explanation of benefits (EOB)** you receive from your insurance company (this document is usually the best and most preferred form of documentation);
2. **Itemized statement** of services provided from your doctor or other service provider; or
3. **Detailed receipt** for prescriptions or over-the-counter (OTC) medicines.

NOTE: If you submit documentation that indicates an **estimated** insurance payment, you will also need to submit a copy of the final EOB from your insurance company which confirms your **actual** (not approximate) out-of-pocket amount.

NOTE: Cancelled checks, credit or debit card receipts, balance forward or payment on account statements, and EOBs which indicate that final insurance payment has not yet been determined are not acceptable forms of documentation.

What types of claims require additional information?

Certain types of claims require documentation that is slightly different or in addition to the four basic information requirements. For example:

- **Insurance premiums**

If your claim is for qualified insurance premiums, documentation must include: (1) name(s) of covered individual(s); (2) premium amount(s); (3) policy period (i.e. coverage month(s)); and (4) insurance provider name and address. This information is typically contained on your premium billing notice. Additionally, if your claim is for long-term care insurance premiums, documentation must also include confirmation that the policy is tax-qualified.

NOTE: Systematic reimbursement of ongoing (e.g. monthly) insurance premiums is available. Complete and submit a Systematic Premium Reimbursement Form available online at hraveba.org. Or, skip the form and set up your systematic reimbursement online after logging in to your account.

NOTE: IRS regulations provide that premiums paid by an employer or deducted pre-tax through a Section 125 cafeteria plan, are **not** eligible for reimbursement. Claims for employee-paid premiums will be denied if the documentation you submit (e.g. paystub) indicates that the premium was deducted pre-tax. If the employee-paid premium was deducted after-tax, a letter from the employer confirming that no pre-tax option exists is required.

- **Dental/Orthodontia**

Generally, reimbursement may not exceed the cost of services provided to date unless (1) you submit proof that you've paid the total charge in full up front or (2) you have a payment contract with your provider. A copy of your payment contract or Truth-in-Lending statement may be required when (1) the total charge is over \$500 and/or (2) the documentation you provide indicates that you've made an initial payment but have not yet paid the total charge in full.

- **Massage therapy**

Massage therapy claims require a letter of medical necessity from your doctor unless you submit (1) an itemized statement of services provided which contains a diagnosis/condition or (2) an EOB from your primary medical insurance carrier which confirms that insurance has paid its portion of the total charge.

- **Vitamins, remedies, and supplements**

Claims for vitamins, remedies, and supplements require a letter of medical necessity from your doctor unless you submit an itemized statement which contains a diagnosis/condition of gastric bypass or cancer treatment.

- **Over-the-counter (OTC) medicines and drugs**

Some OTC medicines and drugs serve both a medical purpose and a personal, cosmetic, or general health purpose. Claims for these “dual purpose” items require a letter of medical necessity from your doctor. The **Qualified Expenses and Premiums** handout available online at hraveba.org contains more details.

NOTE: Per federal healthcare reform laws, OTC medicines and drugs (except insulin) purchased on or after January 1, 2011 must be prescribed by a medical professional or accompanied by a note from a medical practitioner recommending the item to treat a specific medical condition. Thus, OTC medicines and drugs such as aspirin, antihistamines, and cough syrup must be prescribed. Eligible OTC medicines and drugs purchased on or before December 31, 2010 remain reimbursable without a prescription. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.

How long will it take to process my claim and get my reimbursement?

Standard claims turnaround time is up to **five business days** from Meritain Health’s date of receipt, plus **two business days** to execute the necessary investment trades (the two-day investment trade process is necessary in order to transfer the requested funds from the investment company managing your funds to HRA VEBA Trust’s claims payment account). Your direct deposit (if enrolled) or paper check reimbursement is issued after the investment trades are settled. Funds availability is subject to your banking institution’s policies and procedures. If you’re not signed up for direct deposit, remember to allow adequate mail time to

receive your paper check reimbursements in the mail from Meritain Health’s service center in Minneapolis.

To get your money back faster, e-mail or fax your claim to Meritain Health instead of sending it via regular mail. Also, sign up for direct deposit. It’s faster and more secure than waiting to receive paper check reimbursements in the mail.

NOTE: You can check the status of your claim online. After logging in to your account at hraveba.org, click **Claim(s) being processed**. Click **Claims history** to view past claims and explanations of benefits (EOBs).

NOTE: Meritain Health’s system generates separate reimbursements by calendar year. For example, if you submit a single Claim Form that contains expenses incurred during more than one calendar year, your total reimbursable amount will be paid via multiple paper checks or direct deposits (if enrolled).

What communication should I expect from Meritain Health?

Meritain Health provides several forms of participant communication during the claims process. For example:

1. When you submit a claim via email, Meritain Health will send you an auto reply to confirm that your claim has been received.
2. If you’re enrolled in direct deposit, Meritain Health will send you a confirmation e-mail when a direct deposit has been sent to your account. Funds availability is subject to your banking institution’s policies and procedures.
3. Meritain Health will provide you with an **electronic** or **paper** EOB after your claim has been processed. If you’ve authorized e-communication on your account in lieu of paper (recommended), Meritain Health will send you an e-mail notification that your **electronic** EOB is available online. **Paper** EOBs are mailed to participants who are not signed up for e-communication, including those who have enrolled in direct deposit. If you’re not enrolled in direct deposit, an EOB will be attached to your paper check reimbursement.

NOTE: Your EOB will contain a remark code if your claim is denied in whole or in part. The remark code will explain the reason for the denial and, in many cases, tell you how to resubmit the claim.

If you have questions or need assistance, please contact HRA VEBA third-party administrator, Meritain Health, at myHRAVEBA@meritain.com or 1-888-659-8828.