

WageWorks Pay Me Back Claim Form Instructions

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important, but in order for us to process it and your reimbursement quickly and fully, we need you to completely and accurately fill out and submit the WageWorks Pay Me Back (PMB) claim form. To help you, we've provided the below guidelines. Please follow them when completing and submitting your claim.

Tips for Filling out the Pay Me Back Claim Form

- Read every box and provide all requested information pertaining to you and your claim
- Provide the legal name your employer has for you in your official records, not your nickname
- Make sure to total the reimbursement amount and enter it at the box at the bottom of the form
- Make sure you sign the form

Things to Remember When Including Receipts

- Include a receipt for every expense
- A canceled check is not an acceptable form of receipt
- Each receipt must include the date(s) of service
- Do not send original receipts; save them for the IRS
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt
- Do not use a highlighter to highlight the dollar amount on the receipt

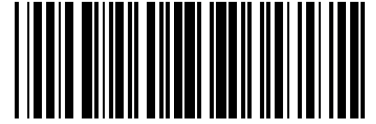
Tips for Submitting the Pay Me Back Claim Form by Fax

- Do not use a cover page
- Use a high-speed fax machine with a transmission speed of at least 9.6 kbps or 15 sec. per page
- If sending Card Verification form along with your Health Care PMB claim, always put the Card Verification form in front of the PMB claim so we can process it first
- Do not combine and submit a co-worker's claims with yours

TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

DO NOT USE A FAX COVER SHEET to ensure speedy processing.



ACCOUNT HOLDER INFORMATION

Grids for Last Name, First Name, Soc. Sec. # (last 4 digits), Employer / Program Sponsor's Name, Zip Code, Birth Month/Day (MM/DD), and Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form 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. (Patient & Relationship is assumed to be Self unless otherwise indicated.)

Signature of Account Holder X _____ Date _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

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

Service Start Date (MM/DD/YY), Relationship to Account Holder, Out-of-Pocket Cost grid

Patient's Name _____

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

Service Start Date (MM/DD/YY), Relationship to Account Holder, Out-of-Pocket Cost grid

Patient's Name _____

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

Service Start Date (MM/DD/YY), Relationship to Account Holder, Out-of-Pocket Cost grid

Patient's Name _____

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

Service Start Date (MM/DD/YY), Relationship to Account Holder, Out-of-Pocket Cost grid

Patient's Name _____

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

Service Start Date (MM/DD/YY), Relationship to Account Holder, Out-of-Pocket Cost grid

Patient's Name _____

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

TOTAL THIS FORM grid

MORE EXPENSES? Complete another form.

TOTAL THIS FORM