How to Submit a Claim for an FSA or HRA

If you have one of the following accounts follow these directions to get reimbursed for eligible or qualified out-of-pocket medical expenses.

- **FSA (Flexible Spending Account)**
  An FSA is a tax-advantaged and employee-funded healthcare spending account that you can use to pay for eligible medical expenses.

- **HRA (Health Reimbursement Arrangement)**
  An HRA is an employer-funded healthcare spending account that you can use to pay for qualified medical expenses.

We offer two easy ways for you to get reimbursed

Stop Here if you already used your healthcare payment card to pay for this medical expense. Card payments do not require a reimbursement.

**Option 1: Submit a Claim Online (fastest results)**

1. Log in to your online account at premera.com. Click on My Plan Information. Then go to the Financial Information section and click on Personal Funding Account.

2. Click Add New Claim from the left-hand menu. Enter the requested information about your claims and continue through the screens to create the Claim Submission Form for your claims.

   **IMPORTANT:** Each Claim Submission Form has a unique bar code and should only be used to submit documentation for that claim submission.

3. Print the Claim Submission Form and fax it, along with the required itemized receipts or other documentation, to 866-741-0386.

**Option 2: Submit a Paper Claim**

1. Complete the Manual Claim Form on the next page.

2. Fax it with itemized receipts or other documentation to 866-741-0386. When you fax the Manual Claim Form and supporting documentation, there is no need to follow up with a hard copy in the mail. Remember to keep the original claim form and supporting documents for your records.

3. If you choose to mail your claim form and documentation instead of faxing, the address is:
   Claims Department
   P.O. Box 1406
   Beltsville, MD 20704

***REMEMBER...ALWAYS SAVE YOUR ITEMIZED RECEIPTS!!!***

Your itemized receipt or documentation must contain the patient name (except for retail store purchases), provider name, date of service, service description, and dollar amount. Do not highlight any portion of the receipt.

Call 800-941-6121 if you need to submit a complex claim or a claim that involves both an FSA and HRA.

For funding account questions call 800-941-6121.
For health plan questions call 800-722-1471.
# Manual Claim Form for an FSA or HRA

Submit this form to get reimbursed for eligible or qualified medical expenses paid out of pocket.

- Do not use this form if expenses were already paid with your healthcare payment card.
- Do not use this form if you already submitted this claim online.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the claims department. Do not highlight any portion of your receipts or documentation. (See Documentation Required section below.)

## Subscriber Information

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<th>Name of Employer</th>
<th>Social Security Number</th>
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## Documentation Required

You must submit documentation with this form that includes the patient’s name, description of service, date of service and amount charged. Examples of acceptable documentation include a copy of the Explanation of Benefits (EOB) from your insurance company, an itemized statement from a provider, or an itemized pharmacy receipt (if applicable to your plan). Cancelled checks, credit card receipts or balance forward statements are not acceptable.

## Claim Details

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<tr>
<th>Date of Service</th>
<th>Patient’s Name</th>
<th>Relationship to Employee</th>
<th>Name of Provider</th>
<th>Description of Service</th>
<th>Reimbursement Amount</th>
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Total $    

## Authorization and Certification

*Read carefully: This claim will not be processed without your signature.*

I certify that these expenses have been incurred by me, my spouse or my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my spouse’s or dependent’s plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse’s income tax return. I further certify that dependent care expenses were incurred for the purpose of allowing me (and my spouse, if applicable) to be gainfully employed.

X

Signature ___________________________ Date __________

## Submission Instructions

For fastest results, fax to: **866-741-0386**
Or mail to: Claims Department  
P.O. Box 1406  
Beltsville, MD 20704

For funding account questions call **800-941-6121**.
For health plan questions call **800-722-1471**.