Health Care Spending Account Claim Form

(Do not fax or mail this instruction page)

This form is used to request reimbursement for health care expenses only. All health care expenses that would be eligible for coverage under your health insurance plan should first be submitted to your health insurance plan before requesting reimbursement from your health care spending account. Please note the following instructions:

- Use this form to request reimbursement of expenses incurred during the plan year and the March 15 grace period immediately following the end of the plan year. (Note: You must be actively enrolled in the plan on December 31 to be eligible for the March 15 grace period.) Claims to be paid out of the prior plan year must be submitted by May 31st.
- If you are submitting expenses for more than one plan year, you can submit a separate form for each year that you are an eligible participant. Complete all information, and be sure to sign the Self Certification in Section 3.
- Each expense you submit must be properly documented.
- You can only be reimbursed for services that have been received/incurred.
- Fax the claim form (and supporting documentation) to **1-855-785-3471.**

References to Verizon as the sponsor of a health or welfare plan means Verizon Communications, Inc.

Option 1: ***Go Paperless!*** You won't need to complete paper forms anymore. Just submit claims online! Visit the BenefitsConnection website at www.verizon.com/benefitsconnection, click on the "Spending Accounts" tab and select "Submit New Claim".

Option 2: Submit your claim using this form.

Step 1: Complete the form

- *Please print in capital letters, with the letters centered in the boxes as shown*

A	B	C	D		1	2	3	4	

- *Complete a separate line for each individual expense.*
- *Use page 3 if you exceed the number of lines available on page 2.*

Step 2: Attach Supporting Documentation

- *See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable by the IRS.*
- *Do not send original receipts or supporting documentation.*
- *Photocopy your receipts or other supporting documentation onto a white, letter-sized sheet of paper.*

Step 3: Certify

- *Read the Certification and then sign and date the form.*

Step 4: Submit

- **FAX** *the form and supporting documentation to* **1-855-785-3471**
- *Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.*
- *Alternatively, you may also mail your claims to:*
  Verizon Benefits Center
  P.O. Box 8999
  Norfolk, VA 23501-8999

Remember: *Keep a copy of the form and all original receipts for your records.*

Type of Supporting Documentation

- Copy of itemized receipts from your pharmacy or medical/dental/vision provider.
- Copy of Explanation of Benefits (EOB) from your insurance company or health care provider.
- Must show:
  - Date(s) of service(s) or purchase.
  - Type of service or name of product.
  - Amount (paid by you).
  - Name of person or organization providing the service or product.
- Cancelled checks or payment statements are not considered acceptable evidence.
- For Over the Counter Medications (e.g. aspirin), other than insulin, please include the appropriate prescription and dated receipt with the name of the claimed medicine.

Please Do

- For multiple expenses on one receipt for the same expense code, use one line to show a total of such expenses (e.g., several over-the-counter items, multiple prescription copays listed on one receipt).
- For expenses that belong to different expense codes or are on different receipts, use one line per expense.
- Use additional copies of Page 2 if your expenses exceed the number of lines available on Page 2.
- Be sure to print legibly and use capital letters.

Please Do Not

- Fill out the form using red or blue ink.
- Highlight receipts or any part of the form.
- Send original receipts.
- Staple copied receipts to the form.
- Write outside of the boxes provided.
- Submit the same claim more than once.
- Fax or mail this Instruction Page.

Health Care Spending Account Claim Form

Fax To: **1-855-785-3471** or Mail To: Verizon Benefits Center P.O. Box 8999 Norfolk, VA 23501-8999

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SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)

ENTERPRISE ID (OPTIONAL)

MMDD OF DATE OF BIRTH

DAYTIME PHONE # (AREA CODE FIRST - NO DASHES)

PARTICIPANT FIRST NAME

PARTICIPANT MIDDLE INITIAL

PARTICIPANT LAST NAME

ZIP CODE

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS)

EXPENSE 1

CATEGORY (MEDICAL, DENTAL, VISION)

PROVIDER NAME

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

AMOUNT $.

PAY FROM PRIOR PLAN YEAR: ☐

Note: Expenses incurred on or before March 15 can be paid from the previous plan year. Default payment is from the current plan year.

EXPENSE 2

CATEGORY (MEDICAL, DENTAL, VISION)

PROVIDER NAME

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

AMOUNT $.

PAY FROM PRIOR PLAN YEAR: ☐

Note: Expenses incurred on or before March 15 can be paid from the previous plan year. Default payment is from the current plan year.

SECTION 3: SELF CERTIFICATION

I certify that the expenses for reimbursement requested above were incurred by me (and/or my spouse and/or eligible dependents, as defined in Internal Revenue Code Section 152) and that the description of these expenses are accurate and meet the guidelines specified under the plan as well as Internal Revenue Code Sections 105 and 125, and supporting IRS Regulations. I certify that any over-the-counter medication or drug requested above was purchased for my (and/or my spouse and/or eligible dependents, as defined in Internal Revenue Code Section 152) medical care and were not purchased for general good health. I further declare that these expenses have not previously been reimbursed to me nor will I seek reimbursement from any other plan covering health benefits. I understand that claims must be filed by the claims filing deadline for the plan year. I further understand that any person who, knowingly and with intent to defraud or deceive any claims reimbursement company, files a statement of claim containing any materially false or misleading information is guilty of a crime and may be liable for substantial civil penalties.

EMPLOYEE SIGNATURE:* _____ DATE: _____

*Your signature is required in order to process your claim for reimbursement

DO NOT SEND ORIGINAL RECEIPTS