

Submitting your Health Care Claim

Review these instructions before submitting your claim...



Go Green! Submit Claims online...

Visit:

<https://myspendingaccount.wageworks.com>

FAX

1-866-643-2219

MAIL

WageWorks Spending Accounts,
P.O. Box 34700, Louisville, KY 40232

Helpful tips to fill the claim form:

SECTION 1: EMPLOYEE INFORMATION

Your details (Employee Name, Employer Name, Address, Phone number and Participant ID) are pre-populated in this section for your convenience.

For any updates to your pre-populated information shown here, please contact your Employer or HR representative.

1 – Select an appropriate Type of Service incurred

SECTION 1: EMPLOYEE INFORMATION

Employee Name: JOHN SMITH
Address: 111 WALNUT
City: NEW YORK
Participant ID: 0123456789

Employer Name: ABC COMPANY
Phone: 987654321

YOUR DETAILS ARE PRE-POPULATED IN THIS SECTION

SECTION 2: YOUR EXPENSE INFORMATION

Service Type	Start Date of Service	End Date of Service	Requested Amount	Patient Name
☐ Office Visit ☐ Medical 1 ☐ OTC Drugs ☐ Dental ☐ Vision ☐ Others	MM/DD/YY 2	MM/DD/YY	\$ 3	4

Optional: If this is a re-submission, please enter your Reference ID here: **5**

SECTION 3: CERTIFICATION

I certify that the expense was incurred for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependent. I understand that where an expense is reimbursed, I am responsible for reimbursing the plan for any such expense. Additionally, these expenses are not being claimed as tax deductions, receipts or other proof of expenses are attached. I have read and understand the instructions on the above page(s).

Signature: **6** Date: MM/DD/YY **XXXCXX**

2 – The Date the Service was incurred (should match the receipts or EOB)

3 – The Amount of the expense

4 – Patient / Service recipient's name

5 – This can be a document ID or any other Reference ID given by WageWorks

6 – Claim Form received without signed certification cannot be processed

Rx Pharmacy 1-1-2015
(999) 999-9999 CUSTOMER RECEIPT

Customer: **SARA SAMPLE**

VIGAMOX 0.5% EYE DROPS
Instill one drop 4 times per day

Pay: \$ 22.54

Rx Pharmacy, Inc. 123 Somewhere St., Anywhere, CT 99999

What do we need on the receipts?

- Date the service was provided or item was purchased
- Amount paid for the service or item
- Description of the service or item
- Name of the service provider or merchant

Important: All over the counter medicine/drugs require a copy of doctor's prescription or a receipt containing an Rx number



- Preferably TYPE your claim information in this form and PRINT
- Only use blue or black ink if filling out this form by hand
- For faster reimbursements, enroll in FREE Direct Deposit online
- Submit your claims on or before the run out date
- You may refer to the online eligible expense guide before submitting claims
- This claim form should be used only for the Health Care out of pocket expenses
- Include all supporting documents/EOB/receipts for all the expenses associated with this claim



- Avoid faxing & mailing the same claim
- Avoid using a photocopy of this claim form
- Refrain from highlighting receipts or any part of the form
- Do not staple copies of your receipts to the claim form
- Don't include this instruction sheet along with your fax/mail
- Refrain from combining multiple expenses - list each expense on a separate claim line (use more forms if needed)

Please note that your employer's pursuing rules determine which account your claim is paid from

For Questions Call Customer Service : 1-888-557-3156

Submitting your Dependent Care Flexible Spending Account Claims

Review these instructions before submitting your claims!



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**WageWorks Spending Accounts,
P.O. Box 34700, Louisville, KY 40232**

IMPORTANT NOTE: Dependent Care FSA Expenses are generally considered eligible when incurred for expenses related to care of a dependent less than 13 years of age. Exceptions may be allowed if documentation verifies that dependent is incapable of self-care. The care must be provided in order to allow the parent(s) or legal guardian(s) to work or seek employment on a full-time basis. Eligible dependents are also defined in your Summary Plan Description.

SECTION 1: EMPLOYEE INFORMATION

Your details (Employee Name, Employer Name, Address, Phone number and Participant ID) are pre-populated in this section for your convenience.

For any updates to your pre-populated information shown here, please contact your Employer or HR representative.

1 – Start date of service as seen on the receipt

2 – End date of service as seen on the receipt

Helpful tips to fill out the claim form:

SECTION 1: EMPLOYEE INFORMATION

Employee Name **JOHN SMITH** Employer Name **ABC COMPANY**

Address **111, WALNUT**

City **NEWYORK** Zip **12345** Phone **987654321**

Participant ID: **1 2 3 4 5 6 7 8 9**

YOUR DETAILS ARE PRE-POPULATED IN THIS SECTION

SECTION 2: YOUR EXPENSE INFORMATION

Important Note: Dependent Care FSA Expenses are generally considered eligible when incurred for expenses related to care of a dependent under 13 years of age. The care must be provided in order to allow the parent(s) or legal guardian(s) to work or seek employment on a full-time basis. Exceptions may be allowed if documentation verifies that dependent is incapable of self-care.

Start Date of Service MM/YY	Start Date of Service MM/YY	Dependent Name	Provider's Names	Amount Dollars/Cents
1	2	3	4	5

Optional: If this is a re-submission, please enter your Reference ID here: **6**

SECTION 3: DEPENDENT CARE SERVICE PROVIDER CERTIFICATION (Required only if receipt is not provided**)**

I certify that the services for the above noted service period(s) and cost(s) have been incurred by the claimant and that these expenses have not previously been certified.

Service Provider Signature **7** Date **MM/YY**

SECTION 4: CERTIFICATION

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me for my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement from any other source. I understand that where an expense is reimbursed and is subsequently deemed ineligible, I am responsible for reimbursing the plan for such expense. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Copy of bills, statements, receipts or other proofs of expense are attached.

Employee Signature **8** Date **MM/YY** **ZDZCZRZ**

3 – Dependent's Name for whom the service was provided

4 – Name of the provider from whom the service was received

5 – Amount

6 – This can be a document ID or any other reference ID given by WageWorks

7 – Signature & date of the dependent care service provider (Mandatory if receipts are unavailable)

8 – Claim Form received without signed certification cannot be processed



- Submit expenses after the services have been incurred
- Preferably TYPE your claim information in this Form and PRINT
- For faster reimbursements, enroll in FREE Direct Deposit online
- Claim line for each dependent must be filled separately
- You may refer to the online eligible expense guide before submitting claims
- Include all supporting documents/receipts for all the expenses associated with your claim (or) have the Dependent Care Service Provider sign Section 3 of this form



- Refrain from highlighting receipts or any part of the form
- Don't use red ink, if filling out this form by hand
- Do not staple copies of your receipts to the claim form
- Don't include this instruction sheet along with your fax/mail
- Copy of Cancelled check or Credit Card receipt are not accepted as valid receipts per IRS

For Questions Call Customer Service : 1-888-557-3156