



Mail Completed Claims To: **Excelsus BlueCross BlueShield,
Utica Region
12 Rhoads Drive
Utica NY 13502**

Claim Form

Subscriber identification number (including ID prefix):

Subscriber's Full Name

Address

City, State, Zip Code

If your address has changed or is incorrect, please call our Customer Service Department at the telephone number listed on the back of the form.

1. Patient Information:

Patient's full name:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to subscriber: <input type="checkbox"/> 1. Self <input type="checkbox"/> 3. Child <input type="checkbox"/> 2. Spouse <input type="checkbox"/> 4. College Student
Patient's date of birth:	If treatment was the result of a non-work injury, give date of injury:
If other than USA, in what country was patient treated?	
Patient diagnosis (illness/injury which required treatment):	

2. Medicare:

Regardless of age, if the patient is covered by Medicare, please be sure to send bills and matching "Explanation of Medicare Benefit".

3. Motor Vehicle or Work Related Illness or Injury:

- a. Was the treatment in any way motor vehicle related? YES NO
 b. Was the treatment the result of a work related illness or injury? YES NO

c. If answer to a. or b. is yes, please describe accident or illness: _____ Date of accident or illness: _____

- Check If: I have other Insurance.
 My other Insurance has changed.

4. Other Insurance Carrier:

If the patient is covered by another health care plan:

If we are your secondary insurance, please be sure to send Itemized bill and matching Explanation of Benefit form(s) from the other insurance company.

Policyholder's name:	Date of birth:	Social Security number:	Relationship to patient:
Name of policyholder's employer:			Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired
Name and address of insurance carrier:		This policy covers the: <input type="checkbox"/> Individual <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> Parent & Child	
Policy or certificate number:	Effective/Cancellation date:	Carrier's telephone number:	Spouse's date of birth:

5. Claim Date and Subscriber Signature: (Unsigned claims will be returned.)

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation. In addition, I hereby authorize any insurance company, organization, employer, hospital, doctor or any other provider of service to release any information requested relevant to this claim and any attached bills.

Date: _____ Subscriber's signature: _____

How To Submit Your Claim

This claim form can be used to submit all your bills. However, a separate claim form must be completed for each person's bills.

If you have any questions about completing the claim form or benefits covered under your contract, please contact us at the number listed on your identification card.

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 12 Rhoads Drive
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In order to process your claim promptly, please refer to the following guidelines to ensure that all necessary information is included:

A. Submit bills for each patient on separate claim forms. A separate claim form is also required for different calendar years. Please submit the original bills with your claim form. Keep copies for your own records. The actual bills are necessary for claims processing.

B. Bills must include:

Name and address (on letterhead) of the provider of service or supply (hospital, doctor, pharmacy, etc.).

Patient's full name.

Type of service or supply (office visits, chest x-ray, etc.).

Place of service (inpatient or outpatient hospital, office, etc.).

Date and charge for each service or supply provided.

Patient's diagnosis (the medical condition for which the patient was treated).

C. Bills for the following services should also include:

FOR THOSE CONTRACTS WITH PRESCRIPTION DRUG COVERAGE - Prescription number, name of drug, and name of prescribing doctor is required.

Private Duty Nurse - The type of Nurse (RN or LPN), license number, the shift and hours worked. A statement of medical necessity from the prescribing doctor.

Durable Medical Equipment (wheelchair, oxygen tank, etc.) - A statement of medical necessity from the prescribing doctor which indicates how long the equipment will be used and a statement from the equipment supplier showing both the rental and purchase price.

D. Cash register receipts, canceled checks, money orders, credit card vouchers and personal lists of services or bills stating only 'balance forward' are not acceptable as substitutes for bills.

Our employees are dedicated to prompt and accurate claim payments to our subscribers. By following these instructions and filling out the claim form completely, you will help us meet our goal of processing your claim in a satisfactory manner.

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

EMPLOYEE INFORMATION (please print)

Employee Name _____ SSN: _____

Address _____ City _____ State _____ Zip _____

Please check this box and complete the address information **ONLY** if your address has changed.

HEALTH CARE EXPENSES – I request reimbursement of the following Health Care expenses that qualify for my dependents and/or myself. Original receipts and/or Explanation of Benefits (EOB's) must be submitted with your signed claim form. **All items requested below must appear on receipts or EOB's.** *Exception – Over The Counter purchases may be accompanied by itemized cash register receipt.

DATE OF SERVICE	PATIENT NAME	PROVIDER NAME	DESCRIPTION OF EXPENSE	AMOUNT
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
TOTAL REQUESTED:				\$

STOP! If you have used your Debit Card for any of the above expenses, you should not also be submitting these expenses for reimbursement, as they have already been "paid" for (or reimbursed) and deducted from your annual account balance. If you have received a letter requesting receipts for Debit Card transactions, please attach your receipts to the letter.

DEPENDENT CHILD CARE EXPENSES – I request reimbursement of the following Dependent Day Care expenses, which qualify under the Plan. Original receipts containing the following information must accompany your signed and dated claim form.

DEPENDENT NAME	RELATIONSHIP	PROVIDER NAME	DATES OF SERVICE		AMOUNT PAID
			From:	To:	
			From:	To:	\$
			From:	To:	\$
			From:	To:	\$
			From:	To:	\$
TOTAL REQUESTED:					\$

ARE ALL OF THE DEPENDENTS ABOVE CLAIMED ON THE EMPLOYEE'S FEDERAL TAX RETURN? YES NO

If you have a spouse, please complete the following:

Is your spouse employed? YES NO If no, is your spouse a full-time student? YES NO

PAY PROVIDER () Please check here if you would like reimbursement made directly to the provider. **NOTE: Only one check per benefit per processing period may be issued.**

EMPLOYEE SIGNATURE

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed and are not reimbursable by any other source, including but not limited to any health plan or insurance coverage. The undersigned states that the information provided is true and accurate, and fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned. The undersigned understands that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, and that the medical expense for non-prescription medications or items were purchased for my use or the use of my spouse or dependents to alleviate or treat a personal injury or sickness and not simply to maintain my or my spouse or dependent's general health, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or child care credit is permitted for amounts for which reimbursement is made.

EMPLOYEE SIGNATURE: _____

DATE: _____

PLEASE BE SURE TO ATTACH ALL RECEIPTS FOR WHICH YOU ARE REQUESTING REIMBURSEMENT. FOR MORE INFORMATION ON PROPER CLAIM FILING PROCEDURES, PLEASE REVIEW THE INFORMATION CONTAINED BELOW.



**Please contact the Claims Department if you have any questions
(716) 564-2747 or toll free (888) 831-9120.**

IN GENERAL

Your Health Care or Dependent Child Care Spending Account(s) can be used to reimburse you for certain expenses that you have incurred. Once you have incurred an expense, follow the rules below on how to file a claim for reimbursement.

You may file claims for reimbursement as often as you like. Once the Plan Year ends you must submit your expenses for receipt by the Administrator not later than XX days after the plan year end. You will be notified periodically during the year of the date claims are due in our office in order to be considered from your account.

HEALTH CARE EXPENSES -

- Your expenses must be for yourself or for your eligible dependents. Eligible dependents include those dependents covered under your health care plan or individuals that qualify as tax dependents as defined by the Internal Revenue Service.
- Eligible expenses include such items as deductibles and co-insurance, office visit and specialist co-pays, prescription co-pays, eye exams, prescription glasses, contacts, laser eye surgery, dental cleanings, x-rays and orthodontic expenses. Please visit our website www.fbaonline.com for more information on eligible expenses.
- If your employer offers a debit card feature, you do not file a manual claim for reimbursement of the same purchases made with the flex debit card. Requests for receipts for debit card transactions will come from Fringe Benefit Analysts, Inc. by mail or email.
- Receipts for Health Care Expenses must include: **the date of service (or purchase), patient name, provider name, a brief description of the expense and amount.** You are not required to have paid for a service in order to seek reimbursement. IRS regulations only require that you properly substantiate that you have incurred an expense within the plan year.
- If an expense or service is covered by insurance, you must first submit a claim to your insurance for payment. When an Explanation of Benefits (EOB) statement is received, you may then submit a claim request for the balance not paid by insurance.

DEPENDENT DAY CARE EXPENSES -

To be eligible for reimbursement the care must be for a qualifying individual so that you (and your spouse if you are married) are able to work. If your spouse does not work, you can still use this account if your spouse is incapacitated or is a full-time student for at least 5 months during the year. A qualifying individual includes the following:

- A child under age 13 for whom you can claim an exemption as dependent for Federal Income Tax purposes.
- Your Spouse, if he/she is incapacitated and unable to care for himself/herself.
- Any other person living in your home; e.g., a child over 13, a parent, an in-law, who is a dependent of yours for Federal Income Tax purposes, and who is incapacitated and unable to care for himself/herself.

Expenses are eligible for reimbursement from your account only if the person providing the care is not your spouse, a child age 19, or any other dependent of yours for whom you can claim an exemption for tax purposes. The kinds of expenses that can be reimbursed from the Dependent Day Care Spending Account include:

- Care furnished in your home to a qualifying individual by a baby-sitter, practical nurse or companion.
- The cost of household services provided by a maid or housekeeper if the services are at least in part for the care of a qualifying individual.
- Cost of nursery school, kindergarten, qualified childcare center, or camp (other than overnight camp) for a dependent under age 13.
- Care services provided outside your home; e.g., in a qualified care center, to qualifying individual other than a dependent under age 13, but only if the qualifying individual spends at least 8 hours a day in your home.

The total amount of reimbursements you can receive from your Dependent Day Care Spending Account for the Plan Year is limited to the lower of your earnings or your spouse's earnings for the year. If your spouse is not employed, he or she will be treated as having earnings of \$200 per month (if you have one qualifying individual) or \$400 per month (if you have two or more qualifying individuals) for which your spouse is either incapacitated or a full-time student.

YOUR MANUAL CLAIM PAYMENT SCHEDULE IS BI-WEEKLY ON FRIDAY