

Medical Reimbursement Claim Form

(SUB Account)

St Paul Electrical Workers Health Plan

1330 Conway St * Suite 130 * St Paul, MN 55106

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Eligible expenses for reimbursement are:

- 1) Annual deductible expenses for a covered participant or dependent, up to the contract benefit limitations for individual and family maximum deductible amounts.
- 2) Co-insurance expenses for a covered participant or dependent, up to the contract benefit limitations for individual and family maximum out-of-pocket amounts, including expenses for hospitalization, surgery, physician services and prescription drugs and other services that may be covered under the contract subject to IRC 213(d).
- 3) Insurance premium expenses for a covered participant or dependent (i.e. spousal insurance co-pay, or participant's required payment to maintain coverage).

Member's Name: _____ Patient's Name _____

Member's SSN #: XXX-XX- _____ Calendar Year _____

Date of Service	Provider's Name or Claim Number	Total Amount You owe

Total Out-of-Pocket Expense requested \$ _____

Out-of-pocket expenses claimed above must include documentation that substantiates the expense actually incurred and its specific nature. **You must attach the Explanation of Benefits (EOB) you received from BLUE CROSS BLUE SHEILD, PLEASE DO NOT SEND BILL.**

- All pages from BLUE CROSS BLUE SHIELD BLUE SHIELD, NOT JUST THE COVER PAGE must be submitted
- Orthodontic reimbursements must have a copy of the contract submitted & receipt of what was paid out of pocket
- Pharmacy reimbursements must have patients name, date & out of pocket amount

You need to file a separate claim form for each person and for each calendar year.

All out-of-pocket expense reimbursement claims must be submitted within **12 months** from the date of service. The amount reimbursed from a participants SUB account shall not exceed the balance of the account on the date the claim for reimbursement was filed. An Administrative processing fee of \$7.00 will be deducted from your SUB account.

Member's Signature _____ Date _____

Send check to: _____ Home or _____ Credit Union

Grand Total _____