SelectAccount℠

MEDICAL EXPENSE REIMBURSEMENT ACCOUNT CLAIM FORM

Use this form for eligible expenses incurred by you or your eligible dependents.

☐ ✔ if this includes documentation for previously denied claim

☐ ✔ if new email address ☐ ✔ if new address

Number of pages _____

Section A – Account Holder Information (Please Print)

ACCOUNT HOLDER'S NAME LAST	FIRST	MIDDLE	SELECTACCOUNT ID# S A
STREET ADDRESS			SOCIAL SECURITY # (if SA# not known)
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
ACCOUNT HOLDER EMAIL ADDRESS		EMPLOYER NAME	

Section B – Claim Detail (Please Print)

All fields in this section must be completed. If information is missing, the processing of your claim may be delayed or denied. Supporting documentation must be attached. See the reverse side of this form for more detailed Claim Filing directions.

Date(s) of Service	Name of Person Receiving Service	Name of Provider of Service	Type of Service/ Supply Provided	Reimbursement Requested
- - to - -				$
- - to - -				$
- - to - -				$
- - to - -				$
- - to - -				$
- - to - -				$
			TOTAL	$

Section C – Account Holder Signature

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify as valid medical expenses according to my Summary Plan Description. These expenses have not been reimbursed and I will not seek reimbursement under my medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan or a flexible spending account plan. I understand that the expense for which I am reimbursed may not be used to claim any Federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me).

ACCOUNT HOLDER SIGNATURE	DATE

Save time: submit this information online. Questions? Call Member Services at (651) 662-5065 or 1-800-859-2144.

Submit online:
Log into your account at www.SelectAccount.com

Send via secured email only:
SelectAccount.documents@SelectAccount.com

Fax to:
651-662-7247
866-231-0214

Mail to:
P.O. Box 64193
St. Paul, MN 55164-0193

How to File a Claim

To receive reimbursement for eligible medical, dental, drug, behavioral health and vision expenses that are not covered by any other plan follow the steps below. If the expense is reimbursable by health insurance, you must submit the expense to the insurance company first.

1. **Sign into your account at www.SelectAccount.com, select submit a claim, and complete the required fields.**
2. **Provide supporting documentation** of your eligible expenses for each claim line item. This documentation is required by the IRS and can be an Explanation of Benefits (EOB), detailed receipt or provider statement. **Cancelled checks do not qualify as IRS acceptable documentation.**

   Supporting documentation must include:

   - Date of service or purchase
   - Name of person receiving service
   - Name of provider of service
   - Type of service or supply provided
   - Amount charged for each service/supply
   - Explanation of benefits from all insurance carriers, if applicable
   - If your Health Reimbursement Arrangement (HRA) rate reimburses you at less than 100%, do not calculate the dollar amount. The reimbursement percentage will automatically be calculated and deducted from your account based on the dollar amount you enter in the reimbursement requested field.

3. **If you can't submit online, fax or mail your claim form with supporting documentation to SelectAccount.**

   - To **fax** your claim form and supporting documentation:
     a) complete and sign the claim form using a dark pen.
     b) make sure your supporting documentation is on white paper
     c) fax to: 651-662-7247 or 1-866-231-0214
   - To **mail** your claim form and supporting documentation
     a) complete and sign the claim form using a dark pen.
     b) include copies of documentation. Do not mail originals.
     c) mail to: SelectAccount, PO Box 64193, St. Paul, MN 55164-0193

Note: Do not highlight items on your claim form or supporting documentation, as it interferes with claims processing. Instead, circle with a dark pen as needed.

4. **Keep a copy** of the claim form and supporting documentation for your records or upload to **eVault** found at **www.SelectAccount.com**.
5. **To receive your reimbursement faster,** sign up for direct deposit by logging into your account at **www.SelectAccount.com**.

Appeal Information

The Explanation of Processing Report explains how your claim was processed based upon the information submitted to us. You or your designated representative may appeal a denial, partial denial, or reduction of your claim by following our appeal procedures. You may contact customer service at 1-800-859-2144 or 651-662-5065 for an explanation of your appeal rights. If you disagree with our decision on your claim, you have the right to submit a written request for an appeal review to SelectAccount, P.O. Box 64193, St. Paul, MN 55164-0193. We can send you a form to file your appeal or you can obtain a copy of the appeal form at www.SelectAccount.com. You have until the later of your plan's run out end date or 180 days from the date of this notice to file an appeal. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or contact our customer service department. You may also submit any documents, records, or other information that relates to your claim for benefits. Upon receipt of your request, we will provide a full and fair review of your appeal and a written notice of our decision either by letter or an explanation on the Explanation of Processing Report within 30 days.

If you are a member of a group plan that is subject to the Employee Retirement Income Security Act (ERISA), once you have exhausted our appeal process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.