Family Savings Plan™ Claim Reimbursement Form

EMPLOYEE INFORMATION

Employee Name: ______________________________ **Employer Name**: ______________________________

PATIENT INFORMATION

Patient Name: ______________________________ (Person who received service)	Last four of Social Security #:__________	Birth date: ________________

SECTION A • PRESCRIPTION REIMBURSEMENT INFORMATION

Date:	Name of drug:	Out-of-pocket amount:
Date:	Name of drug:	Out-of-pocket amount:
Date:	Name of drug:	Out-of-pocket amount:
Date:	Name of drug:	Out-of-pocket amount:
Date:	Name of drug:	Out-of-pocket amount:
Date:	Name of drug:	Out-of-pocket amount:
Date:	Name of drug:	Out-of-pocket amount:
Date:	Name of drug:	Out-of-pocket amount:

Out-of-pocket amount is any amount you paid for medication(s).

SECTION B • MEDICAL SERVICES REIMBURSEMENT INFORMATION

Date of visit:	Out-of-pocket amount:
Date of visit:	Out-of-pocket amount:
Date of visit:	Out-of-pocket amount:
Date of visit:	Out-of-pocket amount:

Out-of-pocket amount is any amount you paid for medical service(s).

SECTION C • ITEMS TO SUBMIT

To reimburse provider	**To reimburse enrollee**	**Please mail, fax or send this form, copies of receipts, Explanation of Benefits, copies of provider bills and any other claim documentation to:**
1. Explanation of benefits 2. Provider bill 3. Date of service	1. Explanation of benefits 2. Receipt of paid service 3. Date of service	Network Health Fax: 262-825-9690 P.O. Box 1725 Secure Email: familysavingsplan@networkhealth.com Brookfield, WI 53008 (Only email documents if you have access to secure email)

Please Note: All medical claims must be submitted through your health plan first. You will receive an Explanation of Benefits (EOB). Only medical expenses approved by your plan will be reimbursed. A drug that is not covered by your plan (not on your plan's formulary list) or a non- medical expense will not be reimbursed. Canceled checks and/or credit card statements are not sufficient proof of your claim. Failure to provide all information will cause a delay in reimbursement.

EMPLOYEE STATEMENT

I hereby certify that the information contained on this *Claim Reimbursement Form* is, to the best of my knowledge and belief, true and correct and each item is eligible for reimbursement. I understand any reimbursed expenses are not tax deductible on my individual or joint federal tax return.

I certify that the amounts above have not been reimbursed under any other health care plan or program, federal, state or government program, worker's compensation or any other policy of health insurance, and that I will not seek reimbursement under any of the aforementioned plans, including a health reimbursement account or flexible spending account.

Employee Signature: ______________________________ **Date**: ________________

Claims for plan year April 1, 2020 to August 31, 2020 must be received no later than November 29, 2020. Claims for plan year September 1, 2020 to August 31, 2021 must receive no later than 90 days after the plan ends or 90 days after termination.

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