Family Savings Plan™ Claim Reimbursement Form for Member Payment

EMPLOYEE INFORMATION

Employee Name: _____ **Employer Name**: _____

PATIENT INFORMATION

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

Please complete Section A and/or Section B for claim reimbursement verification.

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:

Out-of-pocket amount is any amount where a reimbursement is needed 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 where a reimbursement is needed for medical expenses.

SECTION C • ITEMS TO SUBMIT

To reimburse enrollee
1. Explanation of benefits
2. Provider bill or receipt
3. Date of service

Please mail, fax or send this form, copies of receipts, Explanation of Benefits, copies of provider bills and any other claim documentation to:
Network Health
P.O. Box 1725
Brookfield, WI 53008

Fax: 262-825-9690
Secure Email: familysavingsplan@networkhealth.com
(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**: _____

Employees must submit claims as soon as possible, but no later than 180 days from date of service.