Anthem BlueCross BlueShield

Commonwealth of Virginia

Request for Reimbursement

Instructions

1. Employee must complete **Employee Information.**
2. Complete **Claim Information** in its entirety. Please ensure your supporting documentation clearly indicates the requested amount.
3. Check the appropriate box in Supporting Documentation section and attach Acceptable Supporting Documentation as described below. (When attaching small receipts, we suggest you tape them to a standard size sheet of paper.)
   - **a)** Itemized Statement or bill from your provider including:
     - Provider name
     - Patient name
     - Description of service
     - Original date of service (the date of service, not the date of payment must fall within the plan year for which you are enrolled and while you are a participant in the plan)
     - Patient portion of charge(s); or
   - **b)** Explanation of Benefits (EOB) from your insurance carrier; or
   - **c)** Pharmacy Statement including:
     - Patient name
     - Prescribing physician
     - RX number
     - Name of the drug
     - Date the RX was filled
     - Co-payment amount

   ***Unacceptable Documentation includes the following:**
     - Cancelled Checks
     - Credit / cash receipts (An itemized cash register receipt is acceptable for eligible over-the-counter expenses)
     - Balance forward statements
4. Sign and date Employee Certification.
5. **Submit Claims To:**

   Anthem Blue Cross and Blue Shield
   Fax: 888-347-5212 Phone: (877) 451-7244
   P.O. Box 660165
   Dallas, TX 75266-0165

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

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Request for Reimbursement

Employee Information

Account Number | **OR** | **Social Security Number** ___ – ___ – ___

First Name | **Last Name**

E-mail Address (if not on file)

Category*	Patient First Name	Date of Service (MM/DD/YY)	Requested Amount
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$.
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$.
☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ Ortho ☐ OTC		/ /	$.

Travel or mileage reimbursement: Miles must be itemized on a separate page listing date, miles traveled, and type of service. Check current IRS FSA rates per mile at www.benefitadminsolutions.com/anthem $.

*Categories: Rx=Prescription OTC=Over the counter medication Ortho=Orthodontic

TOTAL AMOUNT REQUESTED $.

Supporting Documentation

☐ I have attached copies of Explanation of Benefits (EOBs) for deductible and coinsurance requests.

☐ I have attached itemized bills for any expenses not covered by medical, dental, or vision insurance.

Employee Certification

- I certify the expenses listed for reimbursement are eligible under the Internal Revenue Code and my employer's Benefits Plan ("Plan").
- I certify the services listed above have been received by me, my spouse, or my eligible dependent(s) on the dates indicated.
- I certify the services listed above were not purchased with my Anthem Blue Cross and Blue Shield (Anthem) Benefit Card (if applicable).
- I understand that I may be required to provide further details about some expenses, including a statement from a medical practitioner certifying that the expense is for a specific medical condition.
- I certify these expenses have not been submitted previously for reimbursement under the Plan and such items have not and will not be covered by any other plan or program of any employer or other person.
- I understand if I am covered under more than one health care account, reimbursement will be made according to the payment order determined by my employer.
- I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit.
- If my employer has adopted a grace period, I understand eligible expenses incurred and approved during a grace period will be paid first from any available amounts remaining in the plan year to which the grace period applies and then from the current plan year.
- If claims are submitted out of order, Anthem Blue Cross and Blue Shield (Anthem) will provide a one-time reallocation at the end of the run-out
- period.
- In the event of an erroneous or excess reimbursement, I understand I am required to reimburse the Plan for the improperly paid amount.
- I further understand failure to repay the Plan could result in adverse income tax consequences.
- I understand my employer does not accept responsibility for direct payment to any individuals other than me.

Employee Signature _____ **Date** _____

Claims Fax: 888-347-5212 Phone: (877) 451-7244

The service is administered by CONEXIS, an independent company.