

What to Do

1. Complete all details on the next page. Or if you prefer, submit an electronic claim through your online account at benefitadminsolutions.com/anthem.
2. Check one of the boxes in the Supporting Documentation section.
3. Organize your documentation in the same order listed on the form.
 - Please do not use a highlighter. If necessary, circle an expense on your itemized receipt.
 - Use a paperclip if needed, but do not staple documents.
 - If receipts are small, attach them to a standard size sheet of paper.
4. Sign and date the form.
5. Submit the signed form and copies of supporting documentation. Keep original documents and receipts for your records.

Online: benefitadminsolutions.com/anthem

Mail: Anthem Blue Cross and Blue Shield (Anthem) Claims
P.O. Box 650808
Dallas, TX 75265-0808

Fax: 866-538-6972

Si necesita ayuda en español para entender este documento, puede solicitar sin costo adicional, llamando al número de servicio de cliente que aparece en la parte posterior de su tarjeta de identificación o en la parte inferior de la presente carta.

Acceptable Supporting Documentation

- For office visits — Your health plan's Explanation of Benefits (EOB) statement or an itemized receipt or bill from the provider that includes the patient's name, a description of the service, the original date of service*, and your portion of the charge.
- For prescription drugs — A pharmacy statement or receipt from your pharmacy including the patient's name, the Rx number, the name of the drug, the date the prescription was filled, and the amount.
- For over-the-counter medicines — A written or electronic OTC prescription along with an itemized cash register receipt that includes the merchant name, name of the OTC medicine or drug, purchase date, and amount, OR a printed pharmacy statement or receipt from a pharmacy that includes the patient's name, the Rx number, the date the prescription was filled, and the amount.
- For over-the-counter health care-related products — An itemized cash register receipt with the merchant name, name of the item/product, date, and amount.

Please Note: Credit card receipts, canceled checks, and balance forward statements do not meet the requirements for acceptable documentation.

*The date of service, not the date of payment, must fall within the plan year for which you enrolled and while you are a participant in the plan (exceptions may apply to orthodontia expenses).

The service is administered by CONEXIS, an independent company.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (CompCare), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

SUBMIT THIS PAGE ONLY

Employee Information

Employer Name _____

Employee Name _____ Account Number or SSN _____

Street Address _____ Daytime Phone Number _____

City _____ State _____ ZIP Code _____

Add your email address to know when we processed this claim:

Claim Details

Patient Name	Date of Service	Type of Service	Requested Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
Total Amount Requested (continue on additional page if necessary)*			\$ _____

Supporting Documentation

I have attached my supporting documentation. (*See list of acceptable documentation.)

- Explanation of Benefits (EOBs) for deductible and co-insurance documentation.
- Itemized bills and/or itemized receipts for eligible expenses not covered by medical, dental, or vision insurance.

Employee Certification

- I certify the expenses listed for reimbursement are eligible health care expenses under the Internal Revenue Code and my employer's Flexible 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 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 certify the services listed above were not purchased with my Anthem Benefit Card (if applicable);
- I understand my employer does not accept responsibility for direct payment to any individuals other than the employee;
- I understand the expenses reimbursed may not be used to claim any federal income tax deduction or credit;
- I understand any unused contributions will be forfeited to my employer at the end of the plan year;
- 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;
- 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 may 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;
- By providing my email address, I authorize Anthem to send account information to me via email.

Employee Signature _____

Date _____

**Medical expenses which have been reimbursed under this plan
are not deductible for income tax purposes.**

* Only the total amount supported by the attached documentation (receipts) will be paid.

Fax: 866-538-6972 Phone: 866-599-3061

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