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
   Fax: 866-538-6972

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

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.

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

The service is administered by CONEXIS, an independent company.