Benefits Reimbursement Request Form

- Complete this form and send with supporting documentation to MissionSquare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611 or fax to (888) 665-8495. **You can also submit reimbursement requests and documentation online:** Log into your account at www.missionsq.org, select your RHS plan, and then select Benefits Reimbursement to get to the Meritain Health claims portal.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, amount charged, insurance payments, and the name of the claimant. ***Supporting documentation may consist of itemized statement, explanation of benefits, premium notices. Claims are processed after documents are received in good order.***
- Claims must be submitted within two years from the date of service, but this limit can vary among plans. If you have questions regarding this limit or your claims, contact Meritain at (888) 587-9441.
- Eligible claim expense(s) for reimbursement must be incurred on or after your eligibility date. **Do not** submit claims for services provided prior to your benefit eligibility date.
- If you are able to access funds from your RHS plan in the same year in which you contribute to your Health Savings Account (HSA) administered through another provider, consult your tax advisor prior to submitting a request for reimbursement to your RHS account. There are specific rules governing HSAs when an employee is also enrolled in an HRA, like the RHS plan, that may affect the tax treatment of the HSA contributions.

PART A PLAN AND PARTICIPANT INFORMATION

EMPLOYER PLAN NUMBER:	EMPLOYER PLAN NAME:	STATE:
FULL NAME: *LAST, FIRST, MI*		
SOCIAL SECURITY NUMBER:	PREFERRED PHONE NUMBER:	EMAIL ADDRESS:
MAILING ADDRESS: *STREET*	*CITY*	*STATE* *ZIP*

NOTE: If this is a new address, contact MissionSquare at (800) 669-7400 to update your address. Your check will be mailed to the address on file with MissionSquare.

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES

Use this section to request a reimbursement of non-recurring expenses *(e.g., co-payments, medications, out-of-pocket expenses).*

Summary of Health Care Expenses

Incurred Date*	Participant's Full Name *(last, first, middle initial)*	Provider *(e.g., doctor name/ pharmacy name)*	Name of Patient *(self, spouse, dependent child, other dependent)*	Description of Service	Amount to be Reimbursed
					$
					$
					$
					$
					$
					$
				Total Reimbursement Request:	**$**

**Incurred date is the date of service, not the billing or payment date.*

PARTICIPANT NAME: *LAST, FIRST, MI*	SOCIAL SECURITY NUMBER:

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES *(continued)*

Read carefully and sign below for processing.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS plan. The undersigned also certifies as follows:

- Do not submit claims for charges eligible under your insurance or Medicare. A medical care expense may not be reimbursed from a flexible spending account (FSA) if the expense has been reimbursed or is reimbursable under any other accident or health plan.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the plan for non-qualifying expenses.

Signature: ______________________________ Date: *MM/DD/YYYY* ______________

PART C REQUEST FOR REIMBURSEMENT OF RECURRING EXPENSES

Use this section to request automated reimbursement of recurring expenses *(e.g., insurance premiums)*.

Note: *Payment must be made to the account holder. Payment will not be made directly to an insurance company or other third party.*

You are responsible for ensuring automated reimbursements are for qualifying insurance premiums. You are also responsible for ensuring automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Supporting documentation must show the premium is paid with after-tax funds and include the following: (i) insurance carrier; (ii) type of insurance; (iii) policy holder's name; (iv) amount; and (v) coverage period. **All supporting documentation must show that your coverage is active within 60 days of desired start date of recurring reimbursement.** Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

Fill out SECTION A to start a new recurring reimbursement, SECTION B to change a current recurring reimbursement, or SECTION C to end a current recurring reimbursement.

☐ **SECTION A (Start a new recurring reimbursement.):**

I want to be reimbursed $______________ each **month/quarter (circle month or quarter)** beginning ______________ *(MM/YYYY)* and ending after *** *(MM/YYYY)* ______________ .

☐ **SECTION B (Change a current recurring reimbursement.):**

I want to change my current recurring claim of $______________ to $______________ with the new payment starting *(MM/YYYY)* ______________ and ending after *** *(MM/YYYY)* ______________ . All changes must be received by Meritain Health at least fifteen (15) business days prior to the month you want the change to occur.

☐ **SECTION C (End a current recurring reimbursement.):**

I want to end my current recurring claim of $______________ after I am reimbursed for *** *(MM/YYYY)* ______________ .

Note: ****Payments will continue until one of the following occurs: Your account has been depleted, you've reached your requested end date, or 12 months of premiums have been reimbursed.*

PARTICIPANT NAME: *LAST, FIRST, MI*	SOCIAL SECURITY NUMBER:

PART C REQUEST FOR REIMBURSEMENT OF RECURRING EXPENSES *(continued)*

Read carefully and sign below.

The undersigned certifies all expenses for which reimbursement or payment is claimed were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS plan. The undersigned also certifies as follows:

- The undersigned will not submit claims for charges eligible under any insurance or Medicare. A medical care expense may not be reimbursed from a flexible spending account (FSA) if the expense has been reimbursed or is reimbursable under any other accident or health plan.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes, including federal, state, or local income tax on amounts paid from the plan for non-qualifying expenses.

Signature: ______________________________ Date: *MM/DD/YYYY* ______________

Retain a copy for your records.

Send completed form to:

MissionSquare Retirement Health Savings (RHS) Plan
c/o Meritain Health, Inc.
P.O. Box 30136
Lansing, MI 48909-7611

(888) 587-9441 ■ Fax: (888) 665-8495