WageWorks®

www.wageworks.com

Health Care Account

Pay Me Back Claim Form

WageWorks Pay Me Back Claim Form Instructions

PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important. To ensure we are able to process your reimbursement, please fully complete the WageWorks Pay Me Back Claim Form. Submit your claim form along with your complete documentation of the expense. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

****An electronic claim may be submitted at www.wageworks.com. Log in to your account to verify access to this functionality.****

Tips to Complete the Pay Me Back Claim Form

- Read every box and provide all requested information.
- Type or write legibly.
- Provide the legal name your employer has provided in their official records, not your nickname.
- Include your ID Code which is usually the last four digits of your SSN or employee identification number.
- Remember to sign the form. If the **account holder's signature** is not included, the claim will not be approved.

Things to Remember When Including Receipts

- The itemized receipt or documentation must contain:
  - **Provider Name** – Facility name or person who provided the service or, if a purchase, where item was purchased (i.e. hospital, doctor, pharmacy).
  - **Date of Service** – Date services occurred or date item was purchased.
  - **Service Description** – Detailed description of the service provided or item purchased.
  - **Amount** – The amount charged for the services or product and/or the portion not reimbursed through your insurance carrier.
  - **Patient Name** – Person who received the service or whom the item is for. This may be excluded for retail store purchases.
- Include an itemized and legible receipt for every expense.
- Explanation of Benefits (EOB's) are recommended especially if your insurance carrier covered a portion of the expense.
- Cancelled or Carbon copies of checks are not acceptable forms of receipt documents.
- Handwritten receipts must have stamped provider information.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- Do not use a highlighter to highlight the dollar amount on the receipt.

Tips for Submitting the Pay Me Back Claim Form by Fax

- Do not use a cover page when faxing the claim form.
- Please allow 2 business days from receipt of your claim for processing.
- You can verify the claim status online at www.wageworks.com after processing.
- You will be notified via email of the status of your claim if we have a valid email address on file. To add or change the default email address, log on to www.wageworks.com and select "Edit My Profile" from the welcome screen.
- Make a copy of the form and all attachments; send only copies, keep originals for your records if submitting via postal mail.
- Do not combine and submit a co-workers claim with yours.

FAX: (877) 353-9236, or Mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

WageWorks®

Health Care Account

www.wageworks.com

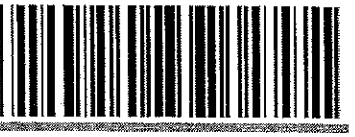
Pay Me Back Claim Form

An electronic claim may be submitted at www.wageworks.com. Log in to your account to verify access to this functionality.

TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

DO NOT USE A FAX COVER SHEET to ensure speedy processing.



ACCOUNT HOLDER INFORMATION

DOE (Last Name) JOHN (First Name)

1234 (ID Code (last 4 digits)*) ABC COMPANY (Employer / Program Sponsor's Name)

12345 (Zip Code) 0913 (Birth Month/Day (MM/DD)) JOHN.DOE@ABCCOMPANY.COM (Email Address (complete only if new))

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the WageWorks Web Site. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com (available upon registration; enter user name and password or click on First Time User? link).

Signature of Account Holder X [signature] **Date** 12-14-10

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

1
- (●) Rx ( ) Dental ( ) Psych / therapy ( ) Ortho
- ( ) Co-payment ( ) Over-the-counter ( ) Chiro ( ) Hospital
- ( ) Office visit ( ) Vision ( ) Lab ( ) X-ray
- ( ) Other:

JOHN DOE — Patient's Name

0 9 1 4 1 0 — Service Start Date (MM/DD/YY)

(●) Self ( ) Qualifying Child
( ) Spouse ( ) Qualifying Relative
( ) Other: — Relationship to Account Holder

$ 2000 — Out-of-Pocket Cost

2
- ( ) Rx ( ) Dental ( ) Psych / therapy ( ) Ortho
- (●) Co-payment ( ) Over-the-counter ( ) Chiro ( ) Hospital
- ( ) Office visit ( ) Vision ( ) Lab ( ) X-ray
- ( ) Other:

JOHNNY DOE JR — Patient's Name

0 9 1 4 1 0 — Service Start Date (MM/DD/YY)

( ) Self (●) Qualifying Child
( ) Spouse ( ) Qualifying Relative
( ) Other: — Relationship to Account Holder

$ 3000 — Out-of-Pocket Cost

3
- ( ) Rx ( ) Dental ( ) Psych / therapy ( ) Ortho
- ( ) Co-payment ( ) Over-the-counter ( ) Chiro (●) Hospital
- ( ) Office visit ( ) Vision ( ) Lab ( ) X-ray
- ( ) Other:

JOANNA DOE — Patient's Name

0 8 1 5 1 0 — Service Start Date (MM/DD/YY)

( ) Self (●) Qualifying Child
( ) Spouse ( ) Qualifying Relative
( ) Other: — Relationship to Account Holder

$ 10000 — Out-of-Pocket Cost

4
- ( ) Rx ( ) Dental ( ) Psych / therapy ( ) Ortho
- ( ) Co-payment ( ) Over-the-counter ( ) Chiro ( ) Hospital
- ( ) Office visit ( ) Vision ( ) Lab ( ) X-ray
- (●) Other: URGENT CARE

JONNIE DOE — Patient's Name

0 2 2 2 1 0 — Service Start Date (MM/DD/YY)

( ) Self ( ) Qualifying Child
(●) Spouse ( ) Qualifying Relative
( ) Other: — Relationship to Account Holder

$ 7500 — Out-of-Pocket Cost

5
- ( ) Rx ( ) Dental ( ) Psych / therapy ( ) Ortho
- ( ) Co-payment ( ) Over-the-counter ( ) Chiro ( ) Hospital
- ( ) Office visit ( ) Vision ( ) Lab ( ) X-ray
- (●) Other: MEDICAL EQUIPMENT

JOHN DOE — Patient's Name

1 2 0 3 1 0 — Service Start Date (MM/DD/YY)

(●) Self ( ) Qualifying Child
( ) Spouse ( ) Qualifying Relative
( ) Other: — Relationship to Account Holder

$ 2801 — Out-of-Pocket Cost

* Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

$ 25301 — TOTAL THIS FORM

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

MORE EXPENSES? Complete another form.

WageRx

RX refills just got easier!

Date 9/14/2010

WageRx
123 Anystreet Cr
Anytown, AS 10000
Phone 123-456-7891
Fax 123-456-7890
help@wagerx.com

SHIP TO John Doe
123 Any Street
Any Town, AS 20000
Phone 987-654-3210
Customer ID 8688965

BILL TO John Doe
123 Any Street
Any Town, AS 20000
Phone 987-654-3210
Customer ID 8688965

Order Date	Order Number	Job
09/14/2010	123456789	

RX #	Description	Cost	Insurance	Patient
987654	ABC Drugs 10 mg	167.88	147.88	20.00
	Insurance claim submitted on 09/14/10			
	Patient Payment collected via AMEX			-20.00

Thank you for your business!

ABC Clinic-123 Ina St., Ina town, AS 10000-123-456-7898	**Amount $30.00**
Description	**Johnny Doe Jr. Co-Pay for office visit with Dr. Jones**
Payment Method	**Check #12345**
Received by	**R Adams**
Date	**09/14/2010**

The Valley's Hospitals

INVOICE

WageWorks Hospital

Because Health Care Matters

STATEMENT DATE: DECEMBER 14, 2010

PO Box 14053, Lexington, KY 40512
Phone 877.123.4567 Fax 877.765.4321
[e-mail]

John Doe
123 Any Street
Any Town, AS 20000
987.654.3210
Account Number ID 123456789

PATIENT NAME	DATE(S) OF SERVICE	DEPARTMENT	PHYSICIAN
Joanna Doe	08/15/2010-08/15/2010	ER-5400	John Smith MD

DATE	DIAGNOSTIC CODE	PROCEDURE CODE	DESCRIPTION	CHARGES	PAYMENTS
08/15/2010	480.8	99211	Hospital Charges for visit 123456	5789.54	
10/28/2010			Insurance Payments		1158.43
10/28/2010			Insurance Adjustments		4531.11

PATIENT RESPONSIBILITY	100.00
PATIENT PAYMENTS	0
PATIENT BALANCE	100.00

CACTUS URGENT CARE

123 Cactus Street
Any Town, AS 20000
Tel : 123.456.7890
Fax : 123.456.0987

Account Number: 12345

Guarantor Information:
John Doe
123 Any Street
Any Town, AS 20000

Patient Information :
Jonnie Doe
123 Any Street
Any Town, AS 20000

Visit Information :
02/22/2010 2:15pm office Encounter No. 125435

Provider :
Brian Singer MD

Date Paid	Reference	Operator	Description	Amount	Balance
02/22/2010	Visa	A. Smith	Copay	75.00	

Claim Selected

Member Name: John Doe

Date of Birth: 02/02/

Status: Completed

Type: Medical

Date(s) of Service:

Questions about this claim? Send a Message

12/03/2010 - 12/03/2010

Total Charges Submitted: $713.00

You Pay Out of Pocket: $28.01

Total Paid by Plan: $86.61

Submitted Charge Part 1: $713.00 - Completed

View/Print this Claim Explanation of Benefits

Submitted Charge - Part 1

Date of Services: 12/03/2010 - 12/03/2010

Health Care Professional: Apria Healthcare

Status : Completed

Payment Made to: Provider **EFT Number:** 16120809

Claim Paid on: 12/11/2010

Date of Service/Service Provided	Charges Submitted	Charges at Aetna's Agreed Pricing	Paid By Plan	Not Paid/Excluded by Plan	Applied to Your Deductible	Your Copay	Applied to Your Coinsurance	Rmks
12/03/2010 AEROSOL COMPRESSOR FOR SVNEB	$713.00	$114.62	$86.61	$0.00	$0.00	$0.00	$28.01	
Total	$713.00	$114.62	$86.61	$0.00	$0.00	$0.00	$28.01	
				Your Responsibility: $28.01				