WageWorks®

www.wageworks.com

MEDICARE REIMBURSEMENT ACCOUNT

Pay Me Back Claim Form

- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at **www.wageworks.com** to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or U.S. Mail and sent to the following locations: **Fax:** 877-353-9236, **U.S. Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within two business days after receipt of the form. You may check the status of your claim by logging in to your account at **www.wageworks.com**.

1. ACCOUNT HOLDER:

Last name

First name

Program sponsor's name

ID code (last 4 digits)*

ZIP code

Birth month/day (MM/DD)

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

ELIGIBLE EXPENSES

Expenses for Medicare Part B premiums are covered under this Medicare Reimbursement Plan. Medicare Part D is not eligible for reimbursement.

2. CLAIMS FOR OUT-OF-POCKET EXPENSES

☐ My Medicare premiums are automatically deducted from my Social Security or Annuity check. (Enter annual amount below in Section 3)

Proof of Payment: Please submit a copy of your Cost of Living Adjustment (COLA) statement or Annuity Statement.

☐ I pay my Medicare premiums after tax. They are not automatically deducted from my Social Security or Annuity check. (Enter monthly/quarterly amount below in Section 3)

Proof of Payment: Please submit a copy of your Medicare Bill along with your proof of payment (such as a cleared check or bank or credit card statement).

3. ENTER YOUR SERVICE DATES AND AMOUNT

Your service start date is January 1 of the year for which you are requesting reimbursement, or your effective date, if after the first of the year, or the first of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Your service end date is either December 31 of the year for which you are requesting reimbursement or the last day of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Fill in the total annual or monthly/quarterly amount of your Medicare Part B payment.

DATES OF SERVICE (MM/DD/YY)	NAME	OUT-OF-POCKET COSTS
	Name: _____	$
	Name: _____	$
	Name: _____	$
	CLAIM FORM TOTAL:	$

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. (Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the User Agreement (available upon registration; enter username and password or click on the Employee Registration link).