ThrivePass

Health Care Claim Form

FAX claim form and supporting documentation to 952-541-6377

Total # pages: _____

Please:
- Only fax one claim form (and documentation) at a time
- Use claim form for cover page
- Do not mail originals

PLEASE PRINT

Name _____ Social Security #_____

Address_____ Daytime Phone #_____

_____ Employer Name _____

☐ Please check box for change of address and notify your Human Resources department of the change

FAXed claims are due by noon on the claim cut-off day

Please check one: ☐ This is a New Claim ☐ This is a resubmission

Instructions

- **Form must be fully completed, including signature and date –** *incomplete forms may delay processing*
- **Enter one expense per patient per line** – use multiple claim forms if necessary
- **Attach supporting documentation** – see back of form for documentation requirements
- **Fax & Mailing Tips** – **Colored paper and highlighting does not fax well** – *illegible forms may delay processing*
- **Documentation will not be returned** – please keep copies of your submissions
- **Payments will be made directly to you** – they cannot be assigned to the provider of services
- **E-mail service & Direct Deposit** – visit our website to sign-up (https://thrivepassbenefits.LH1ondemand.com)

Date expense was incurred	Amount to be reimbursed	Brief description of expense (i.e. Med, Dent, RX, Vision)	Patient name

I request payment from my Health Care account for the above expenses. To the best of my knowledge, these expenses are eligible under the plan (see reverse side) and they are for myself or for an eligible dependent. I further certify that these expenses have not been reimbursed under my major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan, and that I will not seek reimbursement under any such plan. I understand that any expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I authorize ThrivePass to contact my providers if my claim documentation is incomplete.

SIGNATURE _____ **DATE**_____
(required)

ThrivePass, P.O. Box 220, Minneapolis, MN 55440-0220
952-541-6366 800-333-5597 952-541-6377 (FAX)
https://thrivepassbenefits.LH1ondemand.com

DO NOT FAX THIS PAGE

Health Care Expenses

IN GENERAL:

- Eligible expenses are amounts paid for the diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Transportation expenses primarily for and essential to medical care may be eligible. Expenditures that are merely beneficial to one's general health are not eligible.
- Expenses incurred by you, your spouse or your eligible dependents that are not reimbursable from another source (i.e. insurance) may be eligible for reimbursement. Expenses are not eligible for domestic partners or other individuals who do not qualify as eligible dependents under your plan (see your SPD for more information).
- Expenses must be incurred during the period of coverage for which you made your election and while you are an active participant in the plan (i.e. after your effective date and prior to your termination date).
- Expenses are incurred on the date services are provided – not when the service or item is billed or paid for.
- Any balance in your account after the claim submission cut-off date for a plan year will be forfeited.
- Eligible expenses covered by medical/dental plans should be submitted to insurance first. Once insurance has paid, you may request reimbursement of deductibles, co-payments, and co-insurances through your FSA.
- Eligible expenses NOT covered by medical/dental plans may be submitted directly by completing the claim form and attaching an itemized statement from your provider.

SPECIAL NOTICE REGARDING OVER-THE-COUNTER ITEMS:

- Over-the-counter *medications* (unless completely excluded under your employer's plan) are eligible for reimbursement – **but only if you have a doctor's prescription**.
- Other non-medicinal OTC items (e.g. bandages, blood pressure monitors, contact lens solutions) are eligible in "reasonable" quantities (3-bottle guideline).
- Remember that adequate documentation is required. Cash register receipts are OK, but the MUST contain the date, dollar amount and specific name of the item in order to be considered for reimbursement. No miscellaneous (e.g., "pharmacy," "Target, 50-count') receipts will be accepted – even if accompanied by a box-top or label.
- **Note that by signing the front of this form, you are certifying that the OTC items have been purchased to treat a presently existing or imminently probably medical condition and that they are not toiletries/cosmetics or items for general health.**

EXAMPLES OF INELIGIBLE EXPENSES:

- Cosmetic procedures or related services / items (dental bleaching, electrolysis, propecia, etc.)
- Weight loss prescriptions and programs (unless used to treat a diagnosed condition and the documentation includes a letter of medical necessity from your physician)
- Also:
  - Vision warranty
  - Marriage counseling
  - Prenatal/birthing classes
  - Vitamins or nutritional supplements
  - Breast pump
  - Sonicare toothbrush/spin brush

DOCUMENTATION:

An Explanation of Benefits from your insurance company is the best type of documentation because it includes the necessary information: date of service, description of service, patient name, amount charged, insurance payment, and we are able to tell what portion of the cost is patient-responsibility.

If you are unable to submit the EOB, submit an itemized statement from the provider, which includes all of the following:

- Date of service
- Patient name
- Provider name
- Description of service
- Amount of expense; indication that payment is for a co-pay
- Insurance payment, if applicable

Please note - Examples of unacceptable documentation are as follows:

- Canceled check
- Credit card receipt or statement
- Cash register receipt (*except for OTC items…the receipt MUST show ACTUAL NAME of the OTC item. "Target 200 Count" is not a specific enough description)*
- Balance forward or balance due statement
- Payment on account receipt

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