HEALTH CARE ACCOUNT- How to request reimbursement?

(Do not fax or mail this instruction page)

VIA BENEFITS™

Options:

1. **Use a Smart-phone:** Download the mobile App **"Via Benefits Accounts"** on your iOS/ Android Smartphone. Take a picture of your receipt and enter the claim details to submit your reimbursement request.

2. **Online Submission:** Log in to your account at www.viabenefitsaccounts.com. Submit your claim online and attach the image or scanned copy of your receipt(s) online.

   Option 1 & 2 are the fastest and most convenient way to complete your claims and send us your documents. Here all images of your receipts are uploaded on a real-time basis. You can upload three image files at a time. Each image file can use as many pages as you need, be sure to use the multi page TIFF or PDF files on your scanner.

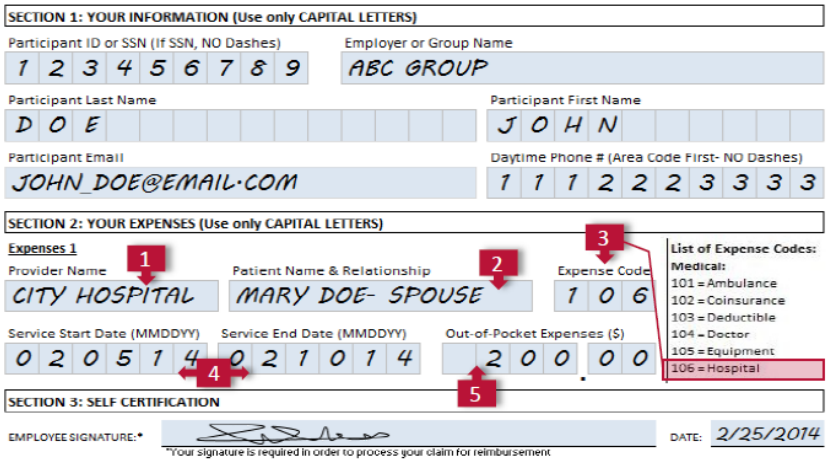
3. **Fax/ Mail:** Enter the claim online at www.viabenefitsaccounts.com then print the online fax cover sheet and submit the cover sheet and receipt. **Or** complete and sign this claim form attaching the copy of your receipt and submit through Fax or Mail.

   Fax: 813.387.0744 **Mail: Accounts Customer Care, PO Box 25172, Lehigh Valley, PA 18002-5172**

   Submitting your Claims via Fax or Mail may take up to 7 - 10 business days from recieved date to process. We strongly urge you to consider using the fast and convenient upload receipt image feature (option 1 & 2) if possible.

Instructions to fill out this form:

- Please print/write in capital letters, with the letters centered in the boxes in blue or black ink.
- Complete all information in the " Your Information" section.
- Use your documentation to complete "Your Expenses" section of the form. Include:
  1. Service Provider Name
  2. Patient Name & Relationship with participant
  3. Write Expense Code using the List available in the right side
  4. Enter Service Start & End Date
  5. Your Out-of-Pocket expenses
- Read the certification and then sign and date the form.



Acceptable Supporting Documentation:

- Copy of Explanation of Benefits(EOB) from your insurance company
- Copy of itemized receipts from your pharmacy or medical/dental/vision provider. Your receipts must show:
  - Date of service or purchase (not the same as the payment date)
  - Type of service or name of product (please check www.viabenefitsaccounts.com for the eligible expenses list. There are some product or services which require a letter of medical necessity from your physician, e.g. Massage Therapy, Wellness service, etc.)
  - Amount Charged (Receipt must clearly show the Patient responsibility)
  - Name of Service Provider (person or organization)

Unacceptable Supporting Documentation:

- Credit/Debit Card receipt, cancelled checks or other payment statements are not considered acceptable evidence.
- Documentation showing a previous balance/ balance forward amount.
- Prepayments are not allowable. Do not submit pre-treatment estimates or estimated insurance statements.
- Do not send original copy of receipts or supporting documentation. Keep original copies with you for any future requirement.

Notes:

- **While submitting any Orthodontia claims** for the first time, please submit the orthodontia contract from the orthodontist along with any proof of payment (such as Credit Card receipt, Cancelled Check etc.).
- **Receipts for over-the-counter (OTC) medications/items** must show the purchase date and the name of the medicine/item. Please circle the expense on your receipt. A valid prescription is required for most of the OTC medications (e.g. Cough & Cold drops, Pain relief drugs, allergy medicine etc.) to get approved. Certain items such as insulin, diabetic supplies, OTC medical devices (crutches, blood sugar monitors, blood pressure monitors, etc.), bandages, contact lens solutions, etc. do not require prescriptions.

HEALTHCARE CLAIM FORM

VIA BENEFITS™

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Go Paperless! You won't need to Complete paper Forms anymore. Download our mobile App "Via Benefits Accounts" on your iOS/ Android Smartphone or visit www.viabenefitsaccounts.com to submit online and expedite

SECTION 1: YOUR INFORMATION (Please use CAPITAL LETTERS)

PARTICIPANT ID / SSN (NO DASHES)

EMPLOYER OR GROUP NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

PARTICIPANT EMAIL

PHONE # (AREA CODE FIRST - NO DASHES)

SECTION 2: YOUR EXPENSES (Please use CAPITAL LETTERS)

EXPENSE 1

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MM/DD/YY) / / - Service End Date (MM/DD/YY) / / | Out of Pocket Expenses ($) $.

EXPENSE 2

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MM/DD/YY) / / - Service End Date (MM/DD/YY) / / | Out of Pocket Expenses ($) $.

EXPENSE 3

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MM/DD/YY) / / - Service End Date (MM/DD/YY) / / | Out of Pocket Expenses ($) $.

EXPENSE 4

Provider Name | Patient Name & Relationship | Expense Code

Service Start Date (MM/DD/YY) / / - Service End Date (MM/DD/YY) / / | Out of Pocket Expenses ($) $.

LIST OF EXPENSE CODES

Medical:
- 101 = Ambulance
- 102 = Coinsurance
- 103 = Deductible
- 104 = Doctor
- 105 = Equipment
- 106 = Hospital
- 107 = Laboratory
- 108 = Pharmacy Prescription
- 109 = Related Travel
- 110 = Therapy
- 111 = Over The Counter (OTC)

Medical - Preventative:
- 201 = Immunization
- 202 = Physicals
- 203 = Screening
- 204 = Smoking Cessation
- 205 = Weight Loss

Dental:
- 301 = Equipment
- 302 = Examination
- 303 = Orthodontia
- 304 = Prescribed Medication
- 305 = Pharmacy Prescription
- 306 = Treatment

Vision:
- 401 = Equipment
- 402 = Examination
- 403 = Prescribed Medication
- 404 = Pharmacy Prescription
- 405 = Treatment

SECTION 3: SELF CERTIFICATION

By signing below, I certify that the information provided on this reimbursement form is correct and that the expenses for which I am requesting or for which I am providing validation were incurred for expenses for the covered participant while eligible under the plan on or after it's effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement.

Employee Signature*:	**Date:**

*Your signature is required in order to process your claim for reimbursement.