Claim Form

Medcom BENEFIT SOLUTIONS

Employee Name ***(Print)*** _____

Employee Social Security Number _____

Employer Name **Effingham County Board of Education**

Don't want to fill out this form? Submit your request for reimbursement online at https://Medcom.wealthcareportal.com or through our Mobile App! Just search "Medcom" in your app store!

YOUR CLAIM CANNOT BE PROCESSED IF THE FOLLOWING SUBSTANTIATION IS NOT ATTACHED

- **Medical Claims**: Most HRA Plans Require an Insurance Explanation of Benefits (EOB). While the EOB is sufficient for FSA Claims, an itemized statement is also acceptable that includes the date of service, services rendered, total charges, and patient responsibility.
- **Dependent Day Care Claims**: Invoices itemized by services incurred with the name of the Day Care Provider, Tax ID Number, services rendered, dates of service, and the name of person receiving the service. Your child's age is also required for these claims.
  - If you would like this claim set up to pay automatically for the entire plan year, please be sure that your itemized receipt shows the total cost of your daycare expenses for the plan year; your claim will be entered and paid in full based on the payroll deposits that accumulate in your account. It will be your responsibility to advise Medcom if you have a cost change.
  - If you would like your Dependent Care claim set up as a recurring claim for the year, please check this box. ☐

Please reimburse me for:

☐ **Expenses Totaling** **$** _____

Please remember that you may only submit requests for reimbursement from Medcom for the benefit plans we administer on behalf of your employer. Please login to your account online at https://medcom.wealthcareportal.com to determine the benefit plans in which you are enrolled.

Expenses Incurred by (NAME)	**Check ✓**							
	Self	Spouse	Child	**Date of Birth** (Required for DCA Claims)	**Provider of Service**	**Incurred Date**	**Itemize & Total Expenses**	**Reimburse Me From This Plan (i.e. FSA, HRA, DCA, PKG):**
						TOTAL SUBMITTED	**$**	

I hereby certify that the above requested reimbursement is for eligible services received by either myself or eligible tax dependents (if any). The above expenses are not payable to me or any eligible tax dependent(s) from any other source, nor will I seek reimbursement under any other plan or source covering health benefits. If the expense(s) is for Day Care, the dependent(s) is an eligible tax dependent. I may not claim the Dependent Care Tax Credit for any reimbursement I receive from this plan.

I further certify that I understand that I must immediately repay ineligible reimbursements. If I have a debit card, it will be deactivated until the full amount of any ineligible expenses is repaid; and, future claims may be offset; or, at my employer's discretion, ineligible expenses may be payroll deducted from my paycheck. Additionally, because unsubstantiated expenses are considered ineligible expenses by IRS regulations, I understand that I am required to keep and submit receipts to substantiate expenses as requested by the claims administrator. And, I understand that funds I repay the Plan for ineligible expenses may be used for reimbursement to me for eligible expenses incurred during the applicable Plan Year.

Employee Signature _____ **Date** _____

Would you like this and future reimbursements direct deposited into your bank account? Sign up for direct deposit by completing the Direct Deposit Authorization form available at www.medcombenefits.com and submit to Medcom along with a copy of a voided check.

Phone: (800) 523-7542, option 1
Fax: (877) 723-0149
MedcomReceipts@medcombenefits.com