PAYFLEX®

OPERS
Retiree Medical Account Claim Form

Fax Completed Form to: 1-888-238-3539
You may also mail a completed form to:
PayFlex Systems USA, Inc.
PO Box 14879
Lexington, KY 40512-4879
Telephone: 1-888-672-9136 (TTY:711)

For questions about your account balance, the status of claim payments, eligible expenses, or how to complete this form, call PayFlex at 1-888-672-9136 (TTY:711).

Section 1	
Account Holder's Name	
Telephone Number	Social Security Number
Address Street City State ZIP code	

Section 2 — *Complete this section if you're requesting payments for premiums or claims.*

Be sure to submit all required documents with this claim.

☐ **Self *(You should check this box if the retiree is deceased and you're an eligible spouse or dependent.)***

Note: When completing the "Amount of Claim" box, give the full amount of the claim you are submitting. This isn't your present balance as that amount may be subject to change. PayFlex will process your claim to the available balance at the time the claim is received. **Example: If the Amount of Claim is $250, and your balance when you submit is $230, you should put $250 in the "Amount of Claim" box. PayFlex will reimburse you $230 or the amount available at the time we process your claim.**

Requesting reimbursement for expenses incurred (Check all that apply.): ☐ Self ☐ Spouse ☐ Dependent	**Name of Person**	
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**
Requesting reimbursement for expenses incurred (Check all that apply.): ☐ Self ☐ Spouse ☐ Dependent	**Name of Person**	
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**
Requesting reimbursement for expenses incurred (Check all that apply.): ☐ Self ☐ Spouse ☐ Dependent	**Name of Person**	
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**
Requesting reimbursement for expenses incurred (Check all that apply.): ☐ Self ☐ Spouse ☐ Dependent	**Name of Person**	
Date(s) of Service From / / Thru / /	Type ☐ Claim ☐ Premium	Amount of Claim **$**

I authorize PayFlex to process my payment in the full amount of my claim at the time it is received. I understand my claim will be processed up to my available balance at the time of submission. I certify that the medical expenses for which I am seeking reimbursement from the Retiree Medical Account have been incurred by the Account Holder or by an individual who qualifies as the Account Holder's spouse or dependent under an OPERS health care plan. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account. I also certify that these expenses have not, and will not, be claimed as a tax deduction or credit on any federal income tax return, or on any state or local tax returns in violation of state or local law. Any person who, knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be liable for substantial civil penalties.

I understand that state laws may prohibit the reimbursement of certain expenses and I certify this reimbursement claim and any related documentation provided complies with my state's law regarding the reimbursement of expenses for certain services.

Signature of **Account Holder** or **Account Holder's Authorized Representative**	Date
Signature of **Power of Attorney**	Date

You can use your Retiree Medical Account to reimburse yourself for eligible expenses. See below for some common expense types. Be sure to note what documents you're required to send with each.

- **Premiums, deductibles and copayments incurred under your Medicare plans (Medicare Advantage / Medigap) or employer-sponsored or individual health plans. This includes your OPERS medical, dental and vision plans.**

  Premiums: When you submit a claim, you should include a premium statement AND a bank statement or a canceled check showing the amount paid. When submitting a request for your premium reimbursement, the coverage period start date should be used as the date of service, not the date of payment. You may provide the OPERS Health Care Premium Receipt as proof of premium payment for your OPERS medical, dental, and vision plans.

  Deductibles / Copayments: When you submit a claim, you should include an Explanation of Benefits (EOB). EOB is the best proof of payment. If you don't have an EOB, you can send an itemized statement or receipt instead, but it must include the following: name of the doctor, hospital or facility that provided treatment, name of the patient, date(s) of service, type of service and the final cost.

- **Medicare Part B premiums**

  The first time you request reimbursement for Medicare Part B Premiums, send us a copy of your *Notice of Medical Insurance Enrollment and Premium Deduction.* It's from the Department of Health and Human Services. Each time thereafter, you only need to complete this form.

- **Other eligible health care expenses. You can find a list of eligible expenses in the Internal Revenue Service (IRS) Publication 502 or visit www.payflex.com.**

  When requesting reimbursement for an eligible expense, you must submit this form and an itemized statement or receipt. It must include the following: name of the doctor, hospital or facility that provided treatment, name of the patient, date(s) of service, type of service and the final cost.

  Claims for some over-the-counter (OTC) drugs or medicines may require you to send us a copy of the prescription with your claim form. You can find the list online at www.payflex.com.

PayFlex has sole discretion to determine if an expense is eligible for reimbursement and the documentation of a claim is complete. If you have any questions about your claim, you can call PayFlex at 1-888-672-9136 (TTY:711).

PayFlex cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions.