



COMPANY NAME: _____

HEALTH CARE ACCOUNT CLAIM FORM

Name: _____ Social Security #: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone #: _____

UNINSURED MEDICAL EXPENSE CLAIMS FOR HEALTH CARE ACCOUNT
PLEASE ATTACH AN EXPLANATION OF BENEFITS STATEMENT
FROM THE INSURANCE COMPANY

Date Service Provided	Name and Address of Service Provider (for example: clinic/ hospital) (Required for sending payment to provider)	Expense Description	Person for Whom Expense Incurred	Net Amount Owed
TOTAL MEDICAL CARE EXPENSE CLAIM				

As the participant in the above noted plans, I hereby authorize EBSC to discuss anything relative to the payment of any of these claims with _____, as my authorized representative.

READ CAREFULLY







The undersigned participant in the plan certifies (i) that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the insurance plan, including the health care account plan with respect to such expenses; and (ii) that he/she has not been reimbursed and will not seek reimbursement from another source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

Employee's Signature: _____ Date: _____

Submit by sending to:
Employee Benefits of St. Cloud
Fringe Department
940 Industrial Drive South, Suite 111
Sauk Rapids, MN 56379
Phone: (800) 682-3826
Scan and email documents to:
Claims@EBSC-online.org
Fax to: (320) 257-8127



INSTRUCTIONS FOR COMPLETING THE CLAIM REIMBURSEMENT FORM

1. Please complete your claim form as follows:
2. Fill in the following information:
 -  Date of service provided
 -  Name and address of service provider (**this information is required** for sending payment to the provider; without this information, we cannot send payment)
 -  Expense description
 -  Patient name
 -  Amount of service not covered by insurance
 -  If you wish to allow EBSC to share any information regarding your claim please complete the authorized representative portion below the claims box with your authorized representative's name.
3. Read the statement regarding submitting your claim, located above the signature line. Sign and date the form. HIPAA privacy rules prevent us from discussing your claim with anyone other than yourself. If you would like to designate an authorized representative who can contact our office about your claims, please complete and return an Authorized Representative form, available from your employer. If you wish to allow someone to inquire about this specific claim only, please add that individual's name above the signature section.
4. When submitting a claim, you must include the Explanation of Benefits Statement (from your insurance carrier) with your reimbursement claim form. Make a copy of the Explanation of Benefits Statement for your records. Submit the claim (using one of the following methods) to:

Mail:

Employee Benefits of St. Cloud
Claims Department
940 Industrial Drive South
Suite 111
Sauk Rapids, MN 56379

E-mail:

Claims@EBSC-online.org

Fax:

(320) 257-8127

5. **The Account Holder is the only person eligible to sign the Reimbursement Claim Form!**

We cannot pay a claim without all of the above information.

If there is any other reason why we cannot make reimbursement to you, we will notify you in writing and you may resubmit the claim for reimbursement with the proper documentation.