HEALTH CARE CLAIM FORM

Use only for Reimbursement Request
FAX or Mail to: Your Insurance Carrier
For additional information, please contact your health plan administrator.

SECTION 1: PATIENT AND INSURANCE INFORMATION

Patient Name (Last, First, Middle Initial)

Date of Birth

Service provided by
DermatologistOnCall® Teledermatology Service E-Visit (CPT: 99444-E/M service via internet or other electronic network)

Name on Insurance

Insurance ID number

Date of Birth (if different from Patient name)

SECTION 2: YOUR HEALTH CARE EXPENSES

Diagnosis and **ICD-9 code** [See treatment plan: e.g. Acne Vulgaris / 706.1]:

Total Amount Requested:

Supporting Documentation Attached?

☐ Yes ☐ No

Examples of documentation include treatment plan and EasyPath payment confirmation or receipt.

SECTION 3: CERTIFICATION Please read carefully before signing.

I affirm that:

- I HAVE NOT BEEN PAID FOR THESE TELEHEALTH SERVICES/EXPENSES FROM MY FSA or HSA AND I HAVE NOT REQUESTED and WILL NOT RECEIVE REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN INCLUDING FEDVIP (Federal Employees Dental and Vision Insurance Program) and FEHB (Federal Employees Health Benefits Program); AND
- I have submitted the above information in good faith and it is correct to the best of my knowledge.

I understand that:

- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) for which I am requesting reimbursement must be incurred during my period of coverage. This coverage begins the next January 1 if I enrolled during the Open Season, or the day after my enrollment is accepted by FSAFEDS, whichever is later. This coverage ends no later than March 15 of the following year, unless my coverage ends sooner due to a Qualifying Life Event.
- I have until April 30 following the end of the Benefit Period or end of Federal Service to submit my claim for reimbursement of eligible expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account(s) in accordance with IRS rules.
- I cannot use health care expenses reimbursed through my general purpose HCFSA or LEX HCFSA as a deduction on my personal income tax return.
- The expenses for which I am requesting reimbursement are for myself, my spouse, my dependent or adult child through age 26. I authorize release of payment through my Flexible Spending Account. I authorize FSAFEDS, or its representatives, to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (including other insurers) to consider the claim for reimbursement under my Flexible Spending Account.

Patient Signature*_____

Date(mm/dd/yyyy)_____

***Your signature and date are required in order to process your claim for reimbursement.**