YOUR spending ACCOUNT™

P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

Health Care Claim Form
PSEG (P2991)

Name, Last

First

M.I.

Address

SSN–Last 4 (Optional)

City

State

Zip Code

Item 1

Date of Service (MM/DD/YYYY)

/ /

Service Provider

Requested Amount

$.

Patient

Service Type

Insert the appropriate letter:

M = Medical **D** = Dental **V** = Vision **H** = Hearing
R = Rx **O** = Over-the-Counter (OTC) Drugs

Item 2

Date of Service (MM/DD/YYYY)

/ /

Service Provider

Requested Amount

$.

Patient

Service Type

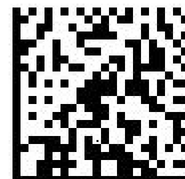
Insert the appropriate letter:

M = Medical **D** = Dental **V** = Vision **H** = Hearing
R = Rx **O** = Over-the-Counter (OTC) Drugs

Employee Certification (Required)

Employee Signature

Date



Employee Certification (Continued)

By adding my signature on the first page, I certify that the information I'm providing is correct and the expenses for which I'm requesting reimbursement, or for which I'm validating:

- Were incurred for services or supplies received by my eligible dependents or me under the plan;
- Were for services or supplies furnished on or after the date my spending account takes effect;
- Haven't been reimbursed in any other way or from any other source and won't be submitted for future reimbursement; and
- Don't include any amounts that are otherwise payable by plans for which my dependents or I are eligible.

For over-the-counter (OTC) drugs, I also certify that any expenses for which I've requested reimbursement, or for which I'm validating:

- Will be used primarily for medical care;
- Will be used to treat an existing medical condition;
- Won't be used for cosmetic purposes;
- Weren't purchased just to benefit general health; and
- Will be used for my treatment or for the treatment of my eligible dependents.

I understand that health care reimbursements aren't eligible deductions on my individual tax return. Claim decisions will be made in accordance with the provisions of the plan. My employer and Hewitt Associates aren't liable for any penalties or damages as a result of an inappropriate claim filed by me.

Health Care Claim Instructions

To have your claim approved, you must sign the enclosed form and fax or mail your claim to Your Spending Account with the required documentation. Once received, Your Spending Account will typically process your claim within ten days.

Documentation You'll Need to Provide

You must provide proper supporting documentation so that your claim can be approved. This includes copies of receipts or other documentation, such as an Explanation of Benefits (EOB) statement from your health plan.

An itemized receipt must include the:

- Date of service;
- Name of service provider, supplier, or pharmacy;
- Name of patient (not required for over-the-counter items);
- Identification of drug or product, or description of service; and
- Amount paid.

If the receipt is handwritten, it must include the service provider's signature. For prescription drugs, remember to submit the receipt that the pharmacist has attached to the prescription, instead of the cash register receipt.

If you have medical insurance, proof of any amount paid by other coverage, such as an EOB, is required. However, EOBs aren't required for prescriptions, vision or hearing expenses, or receipts stating that the amount is for a copayment.

If you have dental insurance, submit your claims to that plan before submitting them to Your Spending Account. If your receipt indicates you have dental insurance, proof of any amount paid by other coverage, such as an EOB, is necessary.

If you lost a receipt, contact your doctor or pharmacy to request a copy, or call your health plan for an EOB. If you don't provide the necessary information, the processing of your claim may be delayed.

Visit the Your Spending Account Web site for more documentation requirements concerning medical necessity, orthodontia, and other services.

Sending Your Claim to Your Spending Account

Send this form and your documentation to Your Spending Account by fax or mail.

Fax: 1-888-211-9900
Mail: Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040

If faxing, be sure to place the form before your itemized receipts and don't include a cover letter.

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