WageWorks Pay Me Back Claim Form Instructions
PLEASE READ THIS BEFORE SUBMITTING YOUR CLAIM FORM

Your claim is important. To ensure we are able to process your reimbursement, please fully complete the WageWorks Pay Me Back Claim Form. Submit your claim form along with your complete documentation of the expense. Please review the guidelines listed below to ensure all necessary information is included when filing your claim.

**An electronic claim may be submitted at www.wageworks.com. Log in to your account to verify access to this functionality.**

Tips to Complete the Pay Me Back Claim Form
- Read every box and provide all requested information.
- Type or write legibly.
- Provide the legal name your employer has provided in their official records, not your nickname.
- Include your ID Code which is usually the last four digits of your SSN or employee identification number.
- Remember to sign the form. If the account holder's signature is not included, the claim will not be approved.

Things to Remember When Including Receipts
- The itemized receipt or documentation must contain:
  - Provider Name – Facility name or person who provided the service or, if a purchase, where item was purchased (i.e. hospital, doctor, pharmacy).
  - Date of Service – Date services occurred or date item was purchased.
  - Service Description – Detailed description of the service provided or item purchased.
  - Amount – The amount charged for the services or product and/or the portion not reimbursed through your insurance carrier.
  - Patient Name – Person who received the service or whom the item is for. This may be excluded for retail store purchases.
- Include an itemized and legible receipt for every expense.
- Explanation of Benefits (EOB’s) are recommended especially if your insurance carrier covered a portion of the expense.
- Cancelled or Carbon copies of checks are not acceptable forms of receipt documents.
- Handwritten receipts must have stamped provider information.
- If you attach multiple receipt pages, circle or check the dollar amount that is being claimed for each receipt.
- Do not use a highlighter to highlight the dollar amount on the receipt.

Tips for Submitting the Pay Me Back Claim Form by Fax
- Do not use a cover page when faxing the claim form.
- Please allow 2 business days from receipt of your claim for processing.
- You can verify the claim status online at www.wageworks.com after processing.
- You will be notified via email of the status of your claim if we have a valid email address on file. To add or change the default email address, log on to www.wageworks.com and select "Edit My Profile" from the welcome screen.
- Make a copy of the form and all attachments; send only copies, keep originals for your records if submitting via postal mail.
- Do not combine and submit a co-workers claim with yours.

FAX: (877) 353-9236, or Mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512
# WageWorks®

**Health Care Account**

**Pay Me Back Claim Form**

**TOLL-FREE FAX: (877) 353 - 9236**

Or, mail to: Claims Administrator, P.O. Box 14053, Lexington, KY 40512

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**ACCOUNT HOLDER INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doe</td>
<td>John</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID Code (last 4 digits)</th>
<th>Employer / Program Sponsor's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234</td>
<td>ABC COMPANY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Birth Month/Day (MM/DD/YY)</th>
<th>Email Address (complete only if none)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2345</td>
<td>0913</td>
<td><a href="mailto:John.Doe@ABCCompany.COM">John.Doe@ABCCompany.COM</a></td>
</tr>
</tbody>
</table>

---

**CERTIFICATION AND AUTHORIZATION**

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.) I have already received these products and services and have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans as stated on the WageWorks Web Site. Use of this service indicates my acceptance of the WageWorks User Agreement at www.wageworks.com; available upon registration; enter user name and password or click on First Time User? link.

**Signature of Account Holder** X

**Date** 12-14-10

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**CLAIMS FOR OUT-OF-POCKET EXPENSES**

<table>
<thead>
<tr>
<th>Rx</th>
<th>Co-payment</th>
<th>Dental</th>
<th>Over-the-counter</th>
<th>Chiro</th>
<th>Hospital</th>
<th>Lab</th>
<th>X-ray</th>
<th>Expensed Date (MM/DD/YY)</th>
<th>Out-of-Pocket Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>09/14/10</td>
<td>$2000</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>09/14/10</td>
<td>$3000</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>08/15/10</td>
<td>$10000</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>02/22/10</td>
<td>$7500</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12/03/10</td>
<td>$2801</td>
</tr>
</tbody>
</table>

**John Doe**

**Patient's Name**

**John Doe**

**Incomplete fields may result in your claim being denied**

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**YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.**

**MORE EXPENSES? Complete another form.**

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*Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.*

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WW-HC-PMB (Dec 2010)
# WageRx

RX refills just got easier!

**WageRx**

**WageRx**

123 Anystreet Cr

Anytown, AS 10000

Phone 123-456-7891

Fax 123-456-7890

help@wagerx.com

**SHIP TO**

John Doe

123 Any Street

Any Town, AS 20000

Phone 987-654-3210

Customer ID 8688985

**BILL TO**

John Doe

123 Any Street

Any Town, AS 20000

Phone 987-654-3210

Customer ID 8688985

---

**Order Date** | **Order Number** | **Job**
--- | --- | ---
09/14/2010 | 123456789 |

<table>
<thead>
<tr>
<th>RX #</th>
<th>Description</th>
<th>Cost</th>
<th>Insurance</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654</td>
<td>ABC Drugs 10 mg</td>
<td>167.88</td>
<td>147.88</td>
<td>20.00</td>
</tr>
</tbody>
</table>

Insurance claim submitted on 09/14/10

Patient Payment collected via AMEX

---

Thank you for your business!
<table>
<thead>
<tr>
<th>Description</th>
<th>Johnny Doe Jr. Co-Pay for office visit with Dr. Jones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Method</td>
<td>Check #12345</td>
</tr>
<tr>
<td>Received by</td>
<td>R Adams</td>
</tr>
<tr>
<td>Date</td>
<td>09/14/2010</td>
</tr>
</tbody>
</table>
# The Valley's Hospitals

## WageWorks Hospital

*Because Health Care Matters*

PO Box 14053, Lexington, KY 40512  
Phone 877.123.4567 Fax 877.765.4321  
[e-mail]

John Doe  
123 Any Street  
Any Town, AS 20000  
987.654.3210  
Account Number ID 123456789

### Statement Date: December 14, 2010

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATE(S) OF SERVICE</th>
<th>DEPARTMENT</th>
<th>PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanna Doe</td>
<td>08/15/2010-08/15/2010</td>
<td>ER-5400</td>
<td>John Smith MD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>DIAGNOSTIC CODE</th>
<th>PROCEDURE CODE</th>
<th>DESCRIPTION</th>
<th>CHARGES</th>
<th>PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/15/2010</td>
<td>480.8</td>
<td>99211</td>
<td>Hospital Charges for visit 123456</td>
<td>5789.54</td>
<td></td>
</tr>
<tr>
<td>10/28/2010</td>
<td></td>
<td></td>
<td>Insurance Payments</td>
<td></td>
<td>1158.43</td>
</tr>
<tr>
<td>10/28/2010</td>
<td></td>
<td></td>
<td>Insurance Adjustments</td>
<td></td>
<td>4531.11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>PATIENT RESPONSIBILITY</th>
<th>PATIENT PAYMENTS</th>
<th>PATIENT BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100.00</td>
<td>0</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Account Number: 12345

Guarantor Information:
John Doe
123 Any Street
Any Town, AS 20000

Patient Information:
Jonnie Doe
123 Any Street
Any Town, AS 20000

Visit Information:
02/22/2010 2:15pm office Encounter No. 125435

Provider:
Brian Singer MD

<table>
<thead>
<tr>
<th>Date Paid</th>
<th>Reference</th>
<th>Operator</th>
<th>Description</th>
<th>Amount</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/22/2010</td>
<td>Visa</td>
<td>A. Smith</td>
<td>Copay</td>
<td>75.00</td>
<td></td>
</tr>
</tbody>
</table>
**Claim Selected**

- **Member Name:** John Doe
- **Date of Birth:** 02/02/1
- **Type:** Medical
- **Date(s) of Service:** 12/03/2010 - 12/03/2010

**Total Charges Submitted:** $713.00
**You Pay Out of Pocket:** $28.01
**Total Paid by Plan:** $86.51

**Submitted Charge Part 1:** $713.00 - Completed

**Submitted Charge - Part 1**

- **Date of Services:** 12/03/2010 - 12/03/2010
- **Health Care Professional:** Apria Healthcare
- **Status:** Completed
- **Payment Made to:** Provider
- **EFT Number:** 16120809
- **Claim Paid on:** 12/11/2010

<table>
<thead>
<tr>
<th>Date of Service/Service Provided</th>
<th>Charges Submitted</th>
<th>Charges at Aetna's Agreed Pricing</th>
<th>Paid By Plan</th>
<th>Not Paid/Excluded by Plan</th>
<th>Applied to Your Deductible</th>
<th>Your Copay</th>
<th>Applied to Your Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/03/2010 AEROSOL COMPRESSOR FOR SVNEB</td>
<td>$713.00</td>
<td>$114.62</td>
<td>$86.61</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$28.01</td>
</tr>
</tbody>
</table>

**Total**

- **Charges Submitted:** $713.00
- **Charges at Aetna's Agreed Pricing:** $114.62
- **Paid By Plan:** $86.61
- **Not Paid/Excluded by Plan:** $0.00
- **Applied to Your Deductible:** $0.00
- **Your Copay:** $0.00
- **Applied to Your Coinsurance:** $28.01

**Your Responsibility:** $28.01