MEDICAL REIMBURSEMENT AND DEPENDENT CARE ACCOUNT CLAIM FORM

STATE OF WYOMING FLEXIBLE SPENDING PLAN

University of Wyoming — **Agency Name**

N/A — **Agency #**

Social Security Number

Last Name, First Name

Home Address

City

State

Zip Code

Daytime Telephone Number OR Email

Check here if this is a new address. ☐

MEDICAL REIMBURSEMENT

This section must be completed in its entirety

Service Provider Name	Date of Service	Patient			Requested Amount	EGI ONLY	
		Name	Relationship	Age		Code	Max

Total Medical Reimbursement Requested $ 0.00

DEPENDENT DAY CARE REIMBURSEMENT

This section must be completed in its entirety

Name & ID# of Provider	Date of Care	Dependent		Requested Amount	Reimburse only Amount Listed	EGI ONLY
		Name	Relationship/Age			

Total Dependent Care Reimbursement Requested $ 0.00

Dependent Care Provider Signature
(Receipt may be attached in lieu of signature)

Please sign on back page

FOR OFFICE USE ONLY

Date Received

Date Paid

You must attach an explanation of benefits (EOB) for any item covered by **any** insurance you have.

These services are not allowable under my and/or my spouse's and/or dependent's insurance policy for the following reason(s):

_____

_____

_____

ITEMIZED INVOICES AND AN EXPLANATION OF BENEFITS FROM INSURANCE COMPANY MUST BE ATTACHED.

GENERAL
Requests for reimbursement may be submitted at any time. Semi-monthly reimbursement will be made directly to you. Reimbursement checks will be issued two times during the month (see the current reimbursement claims processing schedule at: hr.state.wy.us/EGI).

If you apply for reimbursement of expenses that the IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and IRS penalties may apply. Similar treatment may apply to overpayment of reimbursed expenses that have already been reimbursed from some other source.

MEDICAL REIMBURSEMENT
Eligible expenses are qualified medical/dental expenses of the employee, spouse, and dependent(s) that are not eligible for reimbursement from any other source. Expenses that are eligible for reimbursement under a health insurance plan should not be included on this form. A list of typical IRS approved medical/dental expenses is documented in your Flexible Benefit Plan Booklet. General information on the Flexible Benefits Reimbursement Accounts as well as claims status may be obtained by contacting the Employees' Group Insurance Office at 777-6835 or 1-800-891-9241.

WRAP AROUND MEDICAL REIMBURSMENT
This is intended to complement the Health Savings Account. Taking the Wrap Around does NOT enroll you in a Health Savings Account This option does not reimburse services covered by the health insurance including deductibles, coinsurance, and prescription drug expenses for the High Deductible Health Plan (HDHP).

DEPENDENT DAY CARE REIMBURSEMENT
Expenses to provide care for your eligible dependents may qualify for reimbursement. Eligible dependents include children under age 13, a disabled child, a disabled spouse, or a dependent disabled parent.

To be eligible, you must be working while your dependents receive care. Also, if you are married, your spouse must be:

- A wage earner, or
- A full-time student for at least 5 months during the year, or
- Disabled and unable to provide for his or her own care.

Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:

- Licensed nursery schools and day care centers
- Individual – other than your dependents – who provide care for your children in or outside your home, or for your disabled spouse or dependent parent in your home.

Under IRS Regulations, qualified individuals can receive a tax credit for dependent care costs. This credit is claimed on your personal tax return. You CANNOT claim the tax credit for any dependent care costs reimbursed from the Flexible Benefits Reimbursement Account.

I request reimbursement from the Flexible Benefits Reimbursement Account(s) for the expenses itemized above. I hereby certify that I have read and understand the guidelines on this form and that these expenses must qualify for reimbursement under the Internal Revenue Code as outlined on the form.

I further certify that these expenses are not eligible for reimbursement from any other source. I also understand that reimbursement expenses cannot be claimed as credits or deductions on my personal tax return.

_____ _____

Employee's Signature Date

Submit Claims to:

Employees' Group Insurances
Attn: Cafeteria Plan Section
2001 Capitol Avenue B3
Cheyenne, WY 82002
(307) 777-6835

Fax to: 307-777-7685

Email to: egi@wyo.gov

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STATE OF WYOMING FLEXIBLE SPENDING PLAN

Revised 1/2014

RE: Flexible Benefits Claim Submission Requirements

All medical and dependent care claims are scanned into the computer when processed. Therefore, certain standards need to be adhered to when preparing claims for submission.

For **all** claims, please follow these standards:

- Any piece of paper smaller than the standard page size (8 ½ x 11 inches) needs to be taped down on all four edges to a standard sized page.

- Prescription receipts (must include name of patient, medication name, doctor name, and patient price) must be taped on all four edges to a standard size (8 ½ x 11 inch) paper or send a legible copy of all prescription receipts. An alternative is to get a printout from your pharmacy or use a PersonalHealthRX printout from the pharmacy website: www.medimpact.com/member. Cash register receipts are not necessary or acceptable documentation for prescriptions.

- Due to the scanning process, glue and staples cannot be permitted to attach smaller pieces of paper to the standard sized paper. Please attach all documentation pages to your claim form with one paper clip or one staple.

Additional instructions:

- All applicable sections of the claim form must be completed.

- The plan requires the Explanation of Benefits from insurance when the service is an insurance eligible expense, whether you have met your deductible or not. It is not necessary to submit the applicable physician statement/bill.

- Itemized receipts for items not covered by insurance must include all of the following items: date of service, service provider's name, type of service rendered, name of patient, dollar amount of service.

- This page does not need to be submitted with your claim.

Incorrectly submitted claims will be returned to you for correction, thereby delaying reimbursement. If you have any questions, please do not hesitate to contact our office at 1-800-891-9241 or 777-6835.

FOR OFFICE USE ONLY

Date Received _____ Date Paid _____