My claim is a(n):

☐ **Original Submission**

☐ **Resubmission**

Retirement Reimbursement Account (RRA) Claim form

How to complete the form

- Complete sections A, B and C.
- Attach a document showing proof of service, like an Explanation of Benefits (EOB) from your insurance carrier, a prescription drug co-pay receipt, or a print-out of prescriptions purchased. For Medicare premiums, a bill, receipt or other document showing your premium due will suffice. The document(s) you attach must include all of the following:
  1) Provider name and address 2) Patient name 3) Itemized charges 4) Date of service
  5) Type of service
- Cancelled checks, non-itemized receipts and balance due bills are not acceptable proof of expenses.
- If you have questions, please call: (**888) 438-9135.**

A. Employee information

Health Plan Identification (ID) Number (from front of ID card)	Health Plan Name		
Subscriber Name (Last, First)		Phone or Email	
Address	City	State	Zip Code
Patient Name (Last, First)		Patient Date of Birth	

B. Expenses

Start Date of Service MM/DD/YY	End Date of Service MM/DD/YY	Provider of Service (Medicare, doctor or pharmacy), include name and address	Type of Service	Amount of Reimbursement Requested
			☐ Prescription ☐ Medical ☐ Premium	**$**
			☐ Prescription ☐ Medical ☐ Premium	**$**
			☐ Prescription ☐ Medical ☐ Premium	**$**
			TOTAL REIMBURSEMENT REQUEST:	**$**

C. Certification

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- They were incurred for services or supplies by me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my retiree reimbursement account.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my health reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

Subscriber Signature **(Required)**	Date **(Required)**

Mail to: UMR
PO Box 8095
Wausau WI 54402-8095

Fax to: (855) 405-2189

For Inquiries: (888) 438-9135

Reimbursement Instructions – Please Review

Eligible Services and Documentation Requirements:

The expense must be a health-related expense incurred by you or one of your eligible dependents. This means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure of the body. Expenses must be medically necessary and not for cosmetic purposes or general good health.

Supporting Documentation must accompany this request form. Please adhere to the following Dos and Do Nots:

DO	DO NOT
➢ Send an itemized bill or receipts showing the dates of service, type of service, provider name, patient's name and amount of service with this form. ➢ Send a copy of an Explanation of Benefits (EOB) from any insurance plan under which the expense is covered. When applicable your insurance claim must be finalized prior to submitting for reimbursement. ➢ Add the total of all requested amounts in the "TOTAL REIMBURSEMENT REQUEST" field. ➢ Send the documentation on white paper. Carbon copies and colored paper are not legible when scanned. ➢ Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible. ➢ Make a copy of the form and documentation for your personal records.	➢ Do not submit cancelled checks or credit card receipts alone. These are not adequate documentation without supporting itemization. ➢ Do not submit balance forward statements. ➢ Do not submit bank statements. ➢ Do not highlight names, prices or dates on receipts. They are not legible when scanned. ➢ Do not submit handwritten receipts for prescriptions or over-the-counter items. ➢ Do not submit pre-treatment estimates or estimated insurance statements. ➢ Do not submit date expense was paid.

Actual Dates of Service must be indicated on the claim form. The IRS allows reimbursement for services when the care is provided, which may not be the actual date that the patient pays or is formally billed for the charges.

EOB Email Notification allows you to receive an email notifying you once your claim has been processed and an EOB is available to view online. Signing up is easy and convenient at www.compassrosebenefits.com/register.

Letter of Medical Necessity (LOMN) is additional documentation needed when an item normally not considered eligible is needed to treat a specific medical condition. This letter would need to be completed by your provider stating which service or item is needed and for what type of condition. A LOMN is required annually. If you are not sure if a service or item will be covered please review the listing of eligible/ineligible items available online, refer to your plan document or please contact UMR customer service.

Examples of items needing a LOMN are 1) vitamins/supplement 2) massage therapy 3) weight loss programs.