CHOICE™ STRATEGIES
a division of WageWorks
www.choice-strategies.com

Health Care Account
How to File a Claim for Approval

Claim Filing Options:

- **File claim online** - Log in to your account at **www.choice-strategies.com** to submit your claim electronically.
- **File claim via fax or mail** - Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 877-723-0148 , **US Mail:** Choice Strategies, P.O. Box 2205, South Burlington, VT 05407

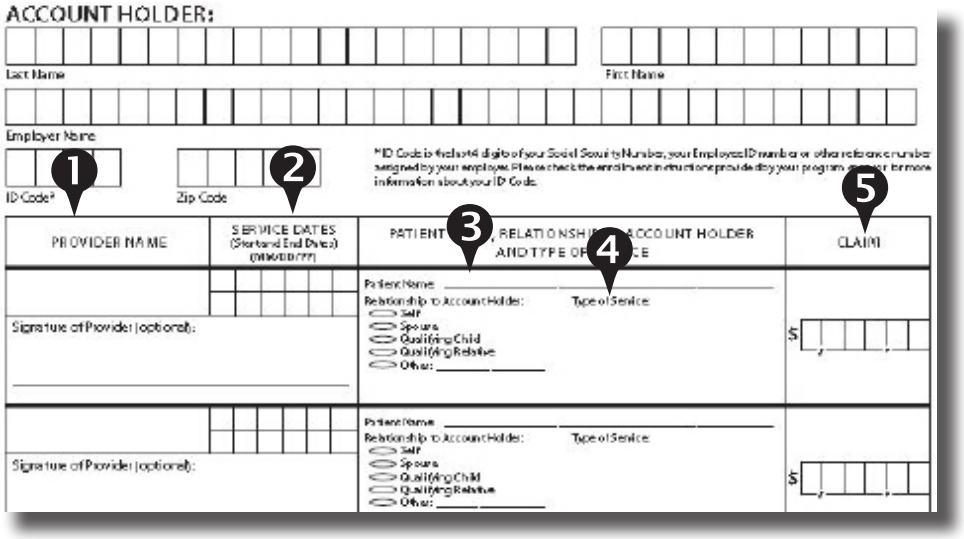
Instructions to fill out this form:

Complete ALL account holder information.

Provide your employer name without abbreviation.

Use your documentation to complete each section of the form, including the following:

① Provider Name
② Service Date(s)
③ Patient Name and Relationship to Account Holder
④ Type of Service
⑤ Patient Responsibility


ACCOUNT HOLDER:

Last Name

First Name

Employer Name

1

ID Code*

2

Zip Code

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

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PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT 3, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF 4CE	CLAIM
Signature of Provider (optional):		Patient Name: Relationship to Account Holder: Type of Service: Self, Spouse, Qualifying Child, Qualifying Relative, Other:	$
Signature of Provider (optional):		Patient Name: Relationship to Account Holder: Type of Service: Self, Spouse, Qualifying Child, Qualifying Relative, Other:	$

Tips For Claim Submission

- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative.
  - A qualifying child is defined as a tax dependent child up to age 26 or any age if permanently disabled.
  - A qualifying relative is someone who resides with you for more than half of the year.
  - Qualifying children and relatives must not provide more than half of his/her own support.
- For a listing of eligible expenses under your plan, please review your plans' funding sheet by logging into your Choice Strategies account, and selecting "My Plan's Forms and Documents" under the Help Center

  If your HRA has a deductible, claims will be applied to the HRA deductible until it has been met. Once met, we will begin reimbursing eligible claims above and beyond the deductible. You can track the status of your HRA deductible online.

  To receive reimbursement faster, select to be reimbursed via direct deposit through your online account.

  If you would like Choice Strategies to pay your provider directly, please file your claim through your online account.
- A letter of medical necessity is required for any expense listed as "Yes (Letter)" on the eligible expense list to establish medical necessity for payment, if eligible under your plan. Cosmetic surgery or procedures (i.e. teeth whitening) are not eligible expenses unless deemed as medically necessary by a licensed physician. A letter of medical necessity form can be obtained at: **https://www.wageworks.com/forms/WW-LTR-OF-MED-NEC.pdf .**

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 5 required pieces of information needed to approve your expense, and are not acceptable for submission.
- Explanation of Benefits (EOBs) are recommended, especially if your insurance covered a portion of the expense.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation – keep the originals for your records if submitting via US Mail.

Tips For Submitting the Pay Me Back Claim Form by Fax

- Do not use a cover page.
- Use a high-speed fax machine with a transmission speed of at least 9.6 kbps or 15 sec. per page.
- Do not combine and submit a co-worker's claims with yours

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- Once processed, the status of your claim can be reviewed through your online account at www.choice-strategies.com.

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Health Care Account
Pay Me Back Claim Form

- **File claim online** - Join the growing majority of participants who submit their claim online for faster service. Log in to your account at www.choice-strategies.com to file your claim electronically and upload your documentation.
- **File claim via fax or mail-** Claim forms may also be filed either via fax or US Mail and sent to the following locations: Fax: 877-723-0148, US Mail: Choice Strategies, P.O. Box 2205, South Burlington, VT 05407
- **Claim processing time -** Claims will be processed within 2 business days after Choice Strategies receives the form. You may check the status of your claim by logging into your account at www.choice-strategies.com.

ACCOUNT HOLDER:

Last Name

First Name

Employer Name

ID Code*

Zip Code

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

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	CLAIM
		Patient Name: _____ Relationship to Account Holder: Type of Service: Self Spouse Qualifying Child Qualifying Relative Other: _____	$
		Patient Name: _____ Relationship to Account Holder: Type of Service: Self Spouse Qualifying Child Qualifying Relative Other: _____	$
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		Patient Name: _____ Relationship to Account Holder: Type of Service: Self Spouse Qualifying Child Qualifying Relative Other: _____	$

More expenses? Please complete another form.

CLAIM FORM TOTAL: $

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 confirm that by requesting reimbursement here that I 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 and as stated on the WageWorks website. Use of this service indicates my acceptance of the WageWorks User Agreement at **www.wageworks.com** (available upon registration; enter username and password or click on First Time User? link).