**Health Savings Account**

**Manual Claim Form Submission Instructions**

We offer four (4) easy ways for you to access your Health Savings Account (HSA). **For fastest results, we encourage you to submit your claim online, or through your funding account mobile app, or by using your healthcare payment card (if applicable).**

|  |  |
| --- | --- |
| **Online** | **Mobile App** |
| * Log in to your online account at Premera.com. Click on “Personal Funding Account,” then on “Manage Your Account.” * Select “Make a Payment,” then “Reimburse Myself,” and follow the steps to enter the claim and upload your documentation. | * Download the funding account mobile app to your Android, iOS, or Windows device. * First time users create a username and password. * Click “Add new claim” from the main screen. Enter the requested information about your claim and continue through the screens to confirm and submit the claim. * You can take a picture of your receipts and upload them with your claim. |
| **Payment Card** | **Paper Submission** |
| * If your account included a payment card, you can use it to directly pay for services at eligible healthcare locations such as doctor’s offices, hospitals, and pharmacies. * Always save your receipts; the IRS may require them at tax time. | * Fax this form to: 443-681-4601 * Or mail to:   Claims Department  P.O. Box 622318  Orlando, FL 32862-2318 |

***REMEMBER TO SAVE YOUR ITEMIZED RECEIPTS*** *– Your itemized receipt or documentation must contain the patient name (except for retail store purchases), provider name, date of service, service description, and dollar amount. Do not highlight any portion of the receipt.*

**Health Savings Account**

**Manual Claim Form**

Use this form to submit your claims for reimbursement of eligible expenses paid out of pocket that have not already been submitted. Do not use this form if you already submitted this claim online, or if the expenses were already paid with your healthcare payment card. Complete all entries on this submission form (please print or type), sign and date and either fax it to 443-681-4601 or mail it to Claims Department, P.O. Box 622318, Orlando, FL 32862-2318.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Account Holder Personal Information** | | | | | | | |
| Name of Employer | | | | Employee Name (last name, first name) | | | |
| Last four (4) digits of Social Security Number | | | | | Date of Birth (mm/dd/yyyy) | | |
|  | | | | | | | |
| **Claim Details** | | | | | | | |
| **Date of Service** | **Patient’s Name** | **Relationship to Employee** | **Name of Provider** | | | Description of Service | **Amount Requested** |
|  |  |  |  | | |  |  |
|  |  |  |  | | |  |  |
|  |  |  |  | | |  |  |
|  |  |  |  | | |  |  |
|  |  |  |  | | |  |  |
| Total | | | | | | | $ |
|  | | | | | | | |
| **Authorization and Certification** | | | | | | | |
| ***Read carefully: This claim will not be processed without your signature*.**  I certify that I am the proper party to receive payments from this account and that all information provided by me is true and accurate. I further certify that no tax advice has been given to me Premera Blue Cross Blue Shield of Alaska or the HSA trustee and that all decisions regarding this distribution are my own. I expressly assume responsibility for any adverse consequences which may arise from this HSA distribution and agree that Premera Blue Cross and/or the HSA trustee shall not be held responsible.  I understand that any distributions made for purposes other than for qualified medical expenses may have tax consequences. I certify that these expenses have been incurred by me or by my eligible spouse or dependent.   |  |  |  | | --- | --- | --- | | **X** |  |  |   Signature Date | | | | | | | |

For funding account questions, call 800-941-6121. For health plan questions, call 800-592-6804.

