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MEDICARE REIMBURSEMENT ACCOUNT
How to File a Claim for Approval

Claim filing options:

- **File claim online:** Log in to your account at **geha.com/HealthEquity** to submit your claim electronically.
- **File claim via fax or mail:** A completed form may be printed and faxed or mailed with documentation.
  Fax: 877-353-9236, **U.S. Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

1. **Account holder** – Please print or write legibly when completing the account holder first and last name. Complete a separate form for your spouse and/or covered dependents.
2. **Claims for out-of-pocket expenses** – Include proof of payment as an attachment to this form that shows you pay Medicare Part B premiums.
3. **Enter your service dates and amount** – Complete this section based on how you pay your Medicare Part B premiums.

Medicare premiums are automatically deducted from my Social Security or Annuity check:

- Include a copy of your Cost of Living Adjustment (COLA) statement or Annuity Statement.
- Your service start day is first of the month in which you are eligible for Medicare Part B for this year. Your service end date is the last day of the year. (If eligible for Medicare Part B on January 1, this will be January 1 to December 31.)
- Enter the annual amount of your Medicare Part B payment (the monthly amount multiplied by the number of months of coverage.)

Premiums are not deducted from your Social Security check:

- Include a copy of your Medicare Bill along with your proof of payment (such as a cleared check or bank or credit card statement).
- Your service start and end dates should represent the period of coverage you have paid for and are seeking reimbursement for. These dates should match your Medicare bill indicating the coverage period you have paid for.
- Enter the monthly/quarterly amount of your Medicare Part B Payment.

Tip for claim submission

- For a complete list of eligible expenses specific to your plan, log in to your account at **geha.com/HealthEquity** and select "Eligible Expense" from the left side of the screen.
- Only submit claims for eligible expenses.

Tips for documentation

- Ensure that the documentation is legible.
- 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 U.S. Mail.

Tips for faxing

- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for viewing claim status

- Please allow two business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log in to your account at **geha.com/HealthEquity** and select "Profile" in the upper right corner of the screen).

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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 **geha.com/HealthEquity** 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 U.S. Mail and sent to the following locations: **Fax:** 877-353-9236, **U.S. Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within two business days after receipt of the form. You may check the status of your claim by logging in to your account at **geha.com/**HealthEquity

1. ACCOUNT HOLDER:

Last name

First name

GEHA MEDICARE REIMBURSEMENT ACCT

Program sponsor's name

ID code (last 4 digits)*

ZIP code

Birth month/day (MM/DD)

* ID code is the last 4 digits of your Subscriber ID. Please check your GEHA member ID card to find your Subscriber ID.

ELIGIBLE EXPENSES

Expenses for Medicare Part B premiums and IRMAA adjustments are covered under this Medicare Reimbursement Plan.

2. CLAIMS FOR OUT-OF-POCKET EXPENSES

☐ My Medicare premiums are automatically deducted from my Social Security or Annuity check. (Enter annual amount below in Section 3)

Proof of Payment: Please submit a copy of your Cost of Living Adjustment (COLA) statement or Annuity Statement.

☐ I pay my Medicare premiums after-tax. They are not automatically deducted from my Social Security or Annuity check. (Enter monthly/quarterly amount below in Section 3)

Proof of Payment: Please submit a copy of your Medicare Bill along with your proof of payment (such as a cleared check or bank or credit card statement).

3. ENTER YOUR SERVICE DATES AND AMOUNT

Your service start date is either January 1 of the year for which you are requesting reimbursement, your effective date if after the first of the year, or the first of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Your service end date is either December 31 of the year for which you are requesting reimbursement or the last day of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Fill in the total annual or monthly/quarterly amount of your Medicare Part B payment.

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Out-of-Pocket Cost

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. (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. Use of this service indicates my acceptance of the User Agreement (available upon registration; enter username and password at **geha.com/HealthEquity**).