Medical Reimbursement Claim Form

Claims received by noon on Fridays will be paid out on Mondays

St Paul Electrical Workers Health Plan
1330 Conway St * Suite 130 * St Paul, MN 55106
Phone: (952)851-5949 Email: spewbenefits@wilson-mcshane.com Fax: 651-776-9973

Eligible expenses for reimbursement are:

1) Annual deductible expenses for a covered participant or dependent, up to the contract benefit limitations for individual and family maximum deductible amounts.

2) Co-insurance expenses for a covered participant or dependent, up to the contract benefit limitations for individual and family maximum out-of-pocket amounts, including expenses for hospitalization, surgery, physician services and prescription drugs and other services that may be covered under the contract subject to IRC 213(d).

3) Insurance premium expenses for a covered participant or dependent (i.e. spousal insurance co-pay, or participant's required payment to maintain coverage).

Member's Name: _____ Patient's Name _____

Member's SSN #: __XXX-XX-_____ Calendar Year _____

Date of Service	Provider's Name or Claim Number	Total Amount You owe

Total Out-of-Pocket Expense requested $ _____

- ***Out-of-pocket expenses claimed above must include documentation*** that substantiates the expense actually incurred and its specific nature. **You must attach the Explanation of Benefits (EOB) all pages you receive from Blue Cross Blue Shield or United Health Care ** PLEASE DO NOT SEND BILL ****
- **Orthodontic reimbursements must have a copy of the contract submitted & receipt of what was paid out of pocket**
- **Pharmacy reimbursements must have patients name, date & out of pocket amount**

You need to file a separate claim form for each person and for each calendar year.

All out-of-pocket expense reimbursement claims must be submitted within **12 months** from the date of service. The amount reimbursed from a participants SUB account shall not exceed the balance of the account on the date the claim for reimbursement was filed. An Administrative processing fee of $7.00 will be deducted from your SUB account.

Member's Signature _____ Date _____

Send check to: _____Home or _____ Credit Union