HealthEquity

Pay Me Back Claims Tips – Submit via Online Portal, Mobile APP EZ Receipts, or Manual Paper Pay Me Back From

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1. Fill out the Pay Me Back claim form entirely either manually or ONLINE PORTAL/Mobile Portal

2. Name must match your former employer's records in top section.

3. Fill out section 2 for a premium or a typical medical, dental, vision RX, claim reimbursement.
   a. Fill in the first day of the month or date for which you are claiming through the last day of the month you are claiming or end date of the service.
   b. The total amount claimed for the entire period.
   c. Select the participant/patient – "Self" for the retiree, "Spouse" or "Dependent depending on who incurred the expense.

   Note: For a **Pay Me Back Recurring Premium Claim for the Current Year You have the option of submitting one claim for future monthly premium reimbursements for the remainder of the calendar year**.

   You will enter the full range of coverage date range as well as the total amount for the multiple months. For example, if you owe a monthly premium of $100.00 beginning February. The claim form indicates 2/1/2023 – 12/31/2023 with an amount of $1100.00. Enter the coverage period as 2/1/2023 – 12/31/2023($100 x 11 months = $1100).

4. Sign the claim form or Submit the Claim online. If you are using the manual form, please fax or mail the claim form and supporting documentation to the phone number/address noted. a. Fax to 877-353-9236 or mail to: Claims Administrator, P.O. Box 14053, Lexington, KY 40512

5. **For Premium claims,** you will then submit/include Documentation showing monthly premium amount from the insurance company (examples of different types of acceptable documentation is listed below) a. Coupon Slips from the insurance company b. Itemized Statement from the insurance company c. Letter from the insurance company.
   For all claims, the documentation must include:
   a. Participant name (name(s) covered individual)
   b. Healthcare company provider name
   c. Date(s) of service (coverage period)
   d. **<u>Type</u>** of service (or type of coverage If submitting for a premium whether Dental, Medical, Vision etc.)
   e. Premium amount
   f. Include one of these proof of payment for premiums.
   - Bank Statements showing check to" xyz insurance company" is cleared
   - Insurance Company Statement showing payment in full for the coverage period
   - Ongoing monthly insurance company statements showing months premium payment
   - A copy of your Social Security "Cost of Living Statement" or Medicare Statement clearly indicating the amount of the monthly Part B, C, or D premium
   - Cancelled check for premium payment to insurance company (copy of front & back of cancelled check)
   - Credit Card Statements showing payment to insurance company

6. If you are submitting for eligible medical, vision, dental, RX claims: Documentation required includes:

a. Participant Name (patient name)
b. Healthcare provider name
c. Date (s) of service
d. Description of Service
e. Amount owed.

IF you need assistance with submitting claims, please contact HealthEquity Member Services at 1-877-924-3967