# Smart-Choice Accounts™

# Health Care Claim Form

IRS rules require Alight Smart-Choice Accounts to validate your eligible expenses before you're reimbursed.

Visit your benefits website for a complete list of eligible expenses and documentation requirements concerning medical necessity, orthodontia, or other services.

## Getting Reimbursed

Once you've sent your required items, Smart-Choice Accounts will process your claim within five business days. If we have your email address, we'll notify you when your items have been received. You can review your claims status on your benefits website or the mobile app.

## Documentation You'll Need to Provide

You must provide proper supporting documentation so your claim can be approved. This includes copies of receipts or other documentation, such as an Explanation of Benefits (EOB) statement from your health plan.

An itemized receipt must include:

- Date of service
- Name of service provider, supplier, or pharmacy
- Name of patient (not required for health care supplies)
- Identification of drug or product, or description of service
- Amount paid

If you have medical insurance, proof of any amount paid by other coverage, such as an EOB, is required. However EOBs aren't required for:

- Prescriptions
- Vision or hearing expenses
- Receipts stating that the amount is for a copayment

If you've lost a receipt, contact your doctor or pharmacy to request a copy or call your health plan for an EOB. If you don't provide the necessary information, the processing of your claim may be delayed.

## Submitting Claims and Receipts

**IMPORTANT NOTE:**

**Prescription or Over-the-Counter Expense?**

An itemized receipt is always required. If the receipt is handwritten, it must include the service provider's signature. For prescription drugs, remember to submit the receipt attached to the prescription, instead of the cash register receipt.

### Online

- Your Benefits Website
- Smart-Choice Mobile App
  (available in app stores at no cost, if your employer offers this feature)

### Fax

1.855.673.6719

If faxing, do not include a cover letter and please place this form before any itemized receipts.

### Mail

Alight Smart-Choice Accounts
P.O. Box 64009
The Woodlands, TX
77387-4009

# Smart-Choice Accounts™

# Health Care Claim Form

## ACCOUNT HOLDER

Last Name

First Name

Employer Name

Last 4 of SSN (Optional)

ZIP Code

## HEALTH CARE CLAIMS

### CLAIM 1

Date of Service (MM-DD-YYYY)

Requested Amount

Patient Name

Provider Name

Mark an "X" in this box if payment is being made to the provider, and complete the additional information

Type of Service: ☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Premium ☐ Prescription* ☐ Over-the-Counter Medicines**

Payee (send payment directly to the specified provider)

Account Number

Address

City

State

Zip Code

### CLAIM 2

Date of Service (MM-DD-YYYY)

Requested Amount

Patient Name

Provider Name

Mark an "X" in this box if payment is being made to the provider, and complete the additional information.

Type of Service: ☐ Medical ☐ Dental ☐ Vision ☐ Hearing ☐ Premium ☐ Prescription* ☐ Over-the-Counter Medicines**

Payee (send payment directly to the specified provider)

Account Number

Address

City

State

Zip Code

More than two expenses? Print another form (forms can't be reused).

*For each prescription claim, please submit a valid prescription and itemized receipt.
**For each over-the-counter medicine claim, please submit an itemized receipt.

## EMPLOYEE CERTIFICATION

By signing below, I certify that the information I'm providing is correct, and that the expenses for which I'm requesting reimbursement (or am validating) were for services or supplies that (1) I (or my eligible dependents) received under the plan, (2) were furnished on or after the date my spending account took effect, (3) haven't been reimbursed through any other source and won't be submitted for future reimbursement, and (4) don't include any amounts that are otherwise payable by plans for which I am (or my dependents are) eligible. For prescription expenses, I am submitting a valid prescription and itemized receipt. I understand that health care reimbursements aren't eligible deductions on my individual tax return. Claim decisions will be made in accordance with the provisions of the plan.

For over-the-counter medicine, I also certify that any expenses for which I'm requesting reimbursement (or am validating) (1) were used primarily for medical care, (2) were used to treat an existing medical condition, (3) were not used for cosmetic purposes, (4) weren't purchased just to benefit general health, (5) were used for my treatment or the treatment of my eligible dependents.


Employee Signature

Date