Wellness Incentive Account Reimbursement Request

See instructions on reverse side. ☐ 1st Submission ☐ Adjustment ☐ Appeal

Enrollee Information (Please Print Clearly)		
Participant Name (Last, First, MI)		
RCBP ID Number	Daytime Phone	
Address		
City	State	ZIP Code

Health Care Expenses (See instructions on reverse)

Patient's Name	Date(s) of Service From	Date(s) of Service To	Type of Service (i.e., copays, deductible, coinsurance, member responsibility)	Provider Name (i.e., physician, hospital, dentist, pharmacy)	Do you have other coverage for this service? (attach EOB)	Amount of Expense to be Reimbursed
1.					☐ Yes ☐ No	
2.					☐ Yes ☐ No	
3.					☐ Yes ☐ No	
4.					☐ Yes ☐ No	
5.					☐ Yes ☐ No	
6.					☐ Yes ☐ No	
7.					☐ Yes ☐ No	
8.					☐ Yes ☐ No	
9.					☐ Yes ☐ No	
10.					☐ Yes ☐ No	
				Total amount of reimbursement requested:		

By my signature below, I certify that:

- The information given on this reimbursement form is complete and correct.
- I have not received reimbursement for these expenses from the reimbursement account or from any other source.
- All health care expenses listed above comply with requirements and guidelines listed on page 2 of this form.

This authorizes RCBP and my hospital, physician or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

Enrollee Signature (If submitted without signature, claim(s) will be denied)	Date (MM/DD/YYYY)

Mail this completed form to:
RCBP, PO Box 14079, Lexington, KY 40512-4079

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Instructions:

1. **Complete the Enrollee Information section** (please print).
2. **Complete the Health Care Expenses section**. Service must be incurred before being reimbursed.
3. **Attach all required supporting documentation** each time you are requesting reimbursement. Please submit copies, not the originals, as these documents will not be returned.
   Supporting Documentation: The type of documentation described under either A or B below must be attached to the completed form.
   A. Explanation of Benefits form (EOB): This is the form you receive each time you or a health care provider submit claims for payment to your health, dental, or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental, or vision care plans, you must attach an EOB. Please do NOT highlight items.
   B. All other Expenses: For expenses not covered at all by your (or your spouse's) health, dental, or vision care plans, reimbursement request will not be processed without acceptable evidence of your expenses. A canceled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain all of the following information (please do NOT highlight items):
      - Name of person for whom the service/supply was provided;
      - Date expense was incurred;
      - Description of service provided (i.e., Office Visit, Dental cleaning, Vision exam, or RX including RX number, NDC, or drug name,);
      - Name of provider (i.e., the physician, hospital, dentist, pharmacy); and
      - Amount of expense(s)
4. Over-the-counter (OTC) medicines or drugs are only eligible for reimbursement with a doctor's prescription. A prescription for a medicine or drug (except insulin) must be a written or electronic order that satisfies the legal requirements for a prescription in that state. It must include Patient Name, RX Number, NDC Code or Drug Name, Date(s) of Service and Amount.
5. **Sign and Date the form** (we cannot honor reimbursement requests without the enrollee's signature).
6. **Mail the completed form and attachment(s)** to:
   RCBP, PO Box 14079, Lexington, KY 40512-4079
7. If you have any questions regarding your request for reimbursement please call RCBP Customer Service at 800 638-8432.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this Program.
- Reimbursement will only be made in accordance with the provisions of the Program. You accept responsibility for the proper treatment of benefits paid under this Program with respect to eligibility, income tax reporting and liability.
- Requests for reimbursement, including all appropriate supporting documentation, must be received no later than December 31 of the year following the year in which the expense was incurred.