HOW TO REQUEST REIMBURSEMENT FROM YOUR HEALTHCARE ACCOUNT

This form is to be used to **request reimbursement for healthcare expenses only**. To view a detailed list of eligible medical expenses, visit www.myshps.com. All healthcare expenses should first be filed under your employer's healthcare plan or any other coverage you may have. Generally, eligible expenses include: allowable expenses covered but not fully reimbursed by any benefit plans, such as co-payments; and allowable expenses NOT covered by any benefit plans, such as over-the-counter medicines.

Step 1: Fill out the form

- Please print in capital letters, with your letters centered in the boxes provided and fill in all ovals as shown:

A	B	C	D		1	2	3	4

● YES ○ NO

- **For Section 2 & 5: Complete a separate line for each individual expense. Do not lump expenses together.**
- Complete all sections of the form. Sign and date the bottom of the form.
- If your expenses exceed the number of lines provided, please use page 3.

Step 2: Attach supporting documentation

- Copy your receipts or other supporting documentation onto a white, letter-sized sheet of paper. Place your receipts so they all face the same direction. And write your Social Security Number or employee ID at the top of the page.

Step 3: Submit your form (Faxing is faster)

- By Fax: Send the form and copied receipts together as one fax. Do not include a fax cover sheet.
- By Mail: Place the form and the supporting documentation into an envelope, apply the correct postage, and mail.
- If you provide your e-mail address, SHPS will e-mail you confirmation we received your form.
- Keep a copy of your completed form and receipts for your records.

Step 4: Receive your reimbursement (Direct Deposit is faster)

- By using Direct Deposit or Electronic Funds Transfer (EFT), you'll receive your reimbursement funds up to five days faster than by receiving a check. To sign up, log in to your account at www.myshps.com and select "Direct Deposit Sign-Up" from the left-side menu.

Type of Supporting Documentation:

- Itemized receipt from your medical, dental or vision provider or pharmacy
- Itemized receipt for over-the-counter medicines–must show the name of the product
- Detailed statement, such as an Explanation of Benefits (EOB) from your insurance company or healthcare provider
- Documentation must show:
  - Date of service or purchase
  - Type of service or name of product
  - Amount (your portion of payment)

Please Do NOT:

- Use red ink
- Use a photocopy of the form
- Highlight receipts or any part of the form
- Staple your copied receipts to the form
- Write outside the boxes provided
- If faxing, fax the same form more than once
- Mail the same form that you have faxed
- Include this instruction sheet with your fax
- Submit expenses for multiple plan years on the same form

COVERAGE CODES – You must include a code on Section 2 of the form.

Medical codes

101 = co-payments

102 = over-the-counter medicines

103 = prescriptions or prescription co-pays

104 = general medical

105 = chiropractic/physical therapy

106 = in-patient hospital expense

107 = massage therapy

108 = counseling/psycho therapy

109 = weight/fitness management*

110 = cosmetic surgery & procedures*

111 = vitamins and supplements*

112 = orthotics

113 = electrolysis/hair restoration*

114 = hearing aids

199 = other medical

Dental codes

201 = co-payments

202 = general dental (cleanings, x-rays, crowns, implants, dentures)

203 = orthodontia

204 = teeth whitening, bonding, veneers*

205 = other dental

Vision codes

301 = co-payments

302 = over-the-counter vision (contact solutions, etc.)

303 = general vision (exams, glasses, contact lenses)

304 = non-prescription sunglasses*

305 = vision correction surgery

Other codes

999 = other (use this code for parking and transporation expenses)

Note: * indicates items that are generally not eligible health care expenses.

New IRS Tax Dependent Definition:

A recent change to the Internal Revenue Code revised the definition of "dependent." Generally speaking, a qualifying child must reside with you for more than half the year and must not provide over half of his/her own support. A qualifying relative is an eligible individual if (1) you provide more than half of the individual's support, and (2) the individual is not a qualifying child of you or any other taxpayer. **Please note that any questions regarding the status of an individual as either a qualifying child or a qualifying relative must be discussed with a qualified tax advisor in conjunction with the provisions of your employer's plan.**

Questions? Need a list of eligible expenses? Go to www.mySHPS.com or call SHPS Customer Service at 1-800-893-0763.

REIMBURSEMENT FORM – HEALTHCARE EXPENSES

Use only CAPITAL LETTERS, completely fill in ovals, and don't use red ink.

FAX TO: 1-866-643-2219 TOLL FREE

For additional expenses, please use next page.

XHXCXRX

Reset Form

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

COMPANY NAME: STATE OF GEORGIA

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

FOR SHPS ONLY

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR HEALTHCARE EXPENSES

EXPENSE 1

COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY) FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS) $.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 2

COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY) FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS) $.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 3

COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY) FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS) $.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

SECTION 3: CERTIFICATION

Please read Certification Statement thoroughly before signing.

I hereby certify that:
- I have read and understand the instructions on page one.
- The information contained within this form is correct.
- I have not received reimbursement previously for these expenses from my Healthcare Account or any other plan and will not seek reimbursement by any other plan.

I understand that:
- Reimbursement is not a guarantee that this payment is tax free.
- Healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Healthcare Account.

I hereby authorize SHPS or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Healthcare Account.

FAX: 1-866-643-2219 Toll Free

MAIL: SHPS Spending Accounts
PO Box 34740
Louisville, KY 40232

PHONE: 1-800-893-0763

Employee Signature _____ Date _____

XHXCXRX

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

Reset Form

USE THIS PAGE FOR ADDITIONAL HEALTHCARE EXPENSES.

BHBABDB

Reset Form

SECTION 4: YOUR INFORMATION (ABBREVIATED)

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

SECTION 5: YOUR ADDITIONAL HEALTHCARE EXPENSES

EXPENSE 4
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 5
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 6
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 7
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 8
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO