Samaritan Health Plans | Supported by Employee Benefits Corporation

Benefits Card Reimbursement Claim Form Instructions

You may submit a manual claim for reimbursement using this form if you had not received your Benefits Card or if your merchant was not able to process your Benefits Card payment at the time of purchase. Please submit one form per member.

To request reimbursement for eligible expenses, read all of these instructions, complete the form on the next page, and return it by mail. Your claim must be received by 90 days after the plan year or quarter in which you received the eligible service/purchased the eligible product. This form should only be used to request reimbursement for eligible expenses covered by your Benefits Card.

1. **Member Information**
   - Complete this section in full.
   - Include your Samaritan Advantage Health Plan member ID; this is required to process your claim.

2. **Expense Information**
   - Please complete one line for each receipt you are submitting for reimbursement.
   - Submit additional forms if you have more than five receipts to submit.

3. **Direct Deposit**
   - Complete this section in full. If you have already submitted your banking information for reimbursement using this form, you do not need to do so again.

4. **Required Documentation**
   Your eligible expenses require an itemized receipt that includes/displays the following:
   - Name of provider or retailer.
   - Date(s) of service.
   - Service description or list of purchased items.
   - Expense amount.
   - Note: Credit card receipts without the above information are not adequate documentation.

5. **Submit Your Claim**
   - Retain original copies for your records and mail the completed form and documentation to:

     Employee Benefits Corporation
     PO Box 44347
     Madison, WI 53744-4347

For more details about eligible and excluded expenses, refer to your current Evidence of Coverage by visiting samhealthplans.org/advantagebenefits.

Questions? Call Samaritan Health Plans Customer Service 800-832-4580 (TTY 800-735-2900).

You can get this document in another language, format, large print or ask for an interpreter at no cost to you. Please call us at 800-832-4580 (TTY 800-735-2900) to request a copy of this document or an interpreter.

Puede obtener este documento en otro idioma, otro formato o en letra grande o pedir un intérprete sin costo alguno para usted. Llámenos al 800-832-4580 (TTY 800-735-2900) para pedir una copia de este documento o un intérprete.

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Benefits Card Reimbursement Claim Form

Member Information

Last Name _____ First Name _____

Phone Number _____ Member ID | | | | | | | | | |

Reason for Manual Claim Reimbursement (Select one):

☐ I have not received my Benefits Card

☐ Merchant was unable to process my Benefits Card payment at the time of purchase

Expense Information (Submit additional forms if you have more than three receipts.)

Date of Service	Provider or Retailer Name	Claim Amount
		$
		$
		$

Direct Deposit (Skip this step if you already provided bank account information using this form.)

Bank Name	Account #	9-digit Routing #	Account Type
			☐Checking ☐Savings

☐ I do not have/do not prefer direct deposit. Please mail me a check, which takes longer than direct deposit.

Important Certifications Regarding This Claim

By submitting this form, I understand, agree with, and certify all of the following statements: (1.) Everything I entered on this form is complete and true. (2.) I must submit only eligible expenses, as defined by my plan, for reimbursement. These expenses have not been, nor will be, reimbursed by any other benefit plan. If I am requesting reimbursement for a dual purpose OTC item, I have discussed the purchase with my personal provider. (3.) Employee Benefits Corporation (EBC), a partner of Samaritan Health Plans, Inc., may obtain and use "protected health information" regarding coverage or benefits under the plan and disclose it to an insurer or other provider of services related to the plan. Any such use or disclosure will be only for purposes of the plan and only for as long as EBC is providing services to the plan. (4.) If I have included direct deposit information above, EBC is hereby authorized to send reimbursements (and appropriate adjusting entries) for this claim and future claims electronically or by any other commercially accepted method to my designated account at the financial institution above. This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it. EBC is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. I must notify EBC immediately of any changes to my direct deposit information.

Mail this form and the required documentation to:
Employee Benefits Corporation, PO Box 44347, Madison, WI 53744-4347