## Montgomery County Claim Form

(Instructions on next page)

### Employee Information

| Last Name, First Name | SSN / Employee ID # |
|---|---|
| | |
| **Home Address** (Street, City, State, Zip Code) ☐ Please update my address on file | **Phone Number** |
| | |
| **Employer Name** | **Email Address** |
| | |

****IMPORTANT****

**All claims processed through a Montgomery County insurance plan will automatically be submitted by the insurance carrier. Please indicate why the below listed expenses will not be included in those direct claim feeds.**

☐ I am not enrolled in the MC Health Insurance ☐ My dependents are not enrolled in the MC Health Insurance

☐ I am not enrolled in the MC Dental Insurance ☐ My dependents are not enrolled in the MC Dental Insurance

☐ I am not enrolled in the MC Vision Insurance ☐ My dependents are not enrolled in the MC Vision Insurance

☐ Expenses will not be submitted to the MC Insurance (such as over-the-counter "OTC" items)

☐ Other – Please explain: _____

### Day Care FSA Expenses

| Service Date(s) | Type of Service | Provider's Name, Tax ID and/or SSN | Services For Whom | Age | Net Cost |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Total Reimbursement Request $ _____**

**Day Care Provider Certification**: I certify that dependent care services were provided as indicated above.

Provider/Facility Name: _____ Provider's Signature **X** _____

Signer's Name (Printed): _____ Date: _____

### Health Care/Limited FSA/HRA Expenses

| Service Date(s) | Type of Service | Provider's Name | Services For Whom | Net Cost |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Total Reimbursement Request $ _____**

### Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my HRA, Health Care ("HCFSA") or Day Care Flexible Spending Arrangement ("DCFSA"), and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HRA, HCFSA or DCFSA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HRA, HCFSA or DCFSA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse and/or dependents. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information, please contact your employer. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. By providing an email address, I consent to receive all possible communications from Navia Benefit Solutions, agents, and subcontractors regarding the Plan via email. I may withdraw consent at any time without charge by contacting Navia by phone, email, or mail. To update your email address contact Navia Benefit Solutions by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HRA, HCFSA and/or DCFSA to be reduced by the amount(s) shown above.

Participant's Signature

**X**_____ Date_____

## Claim Form Instructions

1. Complete employee information section. Be sure to write legibly to ensure proper processing.

2. Itemize your expenses in the table provided and attach copies of your documentation.

   Documentation must clearly show the date of service, type of service, and final cost of service. Examples of acceptable documentation include itemized bills/invoices, or the Explanation of Benefits (EOB) from your insurance carrier.

   - ❖ If the expense is a copay amount (multiple of $5 up to $500), a payment receipt is acceptable documentation.

   Proof of payment is not required to reimburse medical/dental/vision services.

   **Prescriptions**

   Examples of acceptable documentation include the Rx label, payment receipt, or mail order statement showing the date filled, Rx name or Rx #, and cost. You may also submit an itemized printout from your pharmacy.

   **OTC Medications & Drugs**

   Per IRS regulations, OTC medications and drugs with an active ingredient are eligible expenses that can be reimbursed with your FSA (ex. pain relievers, cold/allergy medication, ointments, Antacids).

   **Alternative Treatments**

   Expenses that may be seen as merely beneficial to general health will require a Letter of Medical Necessity (LMN), showing the treatment of a specified medical diagnosis. Examples include vitamins/supplements, herbs, weight loss programs, cosmetic products and procedures. Please have your provider write a letter or complete our Letter of Medical Necessity template.

   **Dependent Care**

   Acceptable documentation includes an itemized bill/invoice, showing the date of service, type of service, and cost of service.
   If the dependent is age 5 or older, the documentation must show the services are "for care," and not educational in nature.

   If you are unable to obtain sufficient documentation, you may have the provider sign the front of this claim form to validate the services being claimed.

   If you would like to automate your recurring daycare expenses, you may do so by completing our Recurring Daycare Claim Form, logging onto our Participant Portal, and selecting the My Recurring Claims tool tile.

   Please DO NOT submit the following types of documentation:
   - ❖ Statements showing estimated/pending insurance
   - ❖ Statements showing the claimed amount as a balance forward/previous balance
   - ❖ Statements showing the claimed amount as a prepayment for future services
   - ❖ Cancelled checks/copies of cashed checks
   - ❖ Personal bank statements

3. Be sure to sign the claim form and submit! Please fax, email or mail a signed claim form, but choose one method only.

   **FSA Claims Submittal & Questions:**

   Email: claims@naviabenefits.com
   Fax: Local (425) 451-7002 or Toll-free (866) 535-9227
   Mail: Navia Benefit Solutions
   PO Box 53250 Bellevue, WA 98015
   Phone: Local (425) 452-3500 or Toll-free (800) 669-3539

   **HRA Claims Submittal & Questions:**

   Email: 105@naviabenefits.com
   Fax: Local (425) 709-7125 or Toll-free (866) 831-6222
   Mail: Navia Benefit Solutions
   PO Box 53250 Bellevue, WA 98015
   Phone: Local (425) 452-3421 or Toll-free (866) 897-1996

   Claims status is available online. Please allow at least two (2) full business days for Navia to process your claim.