VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
BENEFITS REIMBURSEMENT REQUEST FORM - Page 1 of 2

- Complete this form and send with supporting documentation to **VantageCare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611** or fax to 888-665-8495 for processing. Alternatively, you may submit reimbursements and documentation online via Account Access (www.icmarc.org/login). Select your RHS plan and then Claims to get to the Meritain Health claims portal.
- For privacy and security reasons, ICMA-RC removed Social Security Number as an identifier on this form. Please provide your ICMA-RC Reference Code instead of your Social Security Number. If you do not know your Reference Code, it is available through Account Access on the My Profile tab and on your ICMA-RC statements.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, amount charged, insurance payments, as well as the name of the claimant. ***Supporting documentation may consist of: Itemized Bills, Explanation of Benefits, Premium Notices, Itemized Receipts.***
- Eligible claim expense(s) for reimbursement must be incurred on or after your eligibility date. Generally, claims should be submitted within two years from the date of the expense, but this limit may vary among plans. If you have questions regarding this limit or your claims, please contact Meritain at 888-587-9441.

PLEASE NOTE: ***SIGNATURE IS REQUIRED FOR PROCESSING.*** Do **not** submit claims for charges eligible under your insurance or Medicare. A medical care expense may not be reimbursed from a Flexible Spending Account (FSA) if the expense has been reimbursed or is reimbursable under any other accident or health plan. If a medical care expense is eligible for coverage by both a Health Reimbursement Arrangement (HRA) and a health FSA, amounts available under a HRA must be exhausted before reimbursement may be made from a health FSA. This requirement does not apply to medical care expenses which are reimbursed from a health FSA but are not reimbursable by a HRA. In no case may a participant be reimbursed for the same medical care expense by both a HRA and a health FSA. Do **not** submit claims for services provided prior to your benefit eligibility date. Claims are processed upon receipt of documents in good order.

If you are able to access funds from your RHS plan in the same year in which you contribute to your Health Savings Account (HSA) administered through another provider, please consult your tax advisor prior to submitting reimbursement to your RHS account. There are specific rules governing HSAs when an employee is also enrolled in a HRA, like the RHS plan, that may affect the tax treatment of the HSA contributions.

Part A: Plan and Participant Information

Employer Plan Number ____ ____ ____ ____ ____ ____ ____

Employer Name _____

State _____

Participant Name (Last, First, and Middle Initial) _____

Reference Code _____

Daytime Phone Number

(____ ____ ____) ____ ____ ____ – ____ ____ ____ ____

Area Code

Address

_____

Street

_____

City State ZIP

NOTE: If this is a new address, please contact ICMA-RC at 800-669-7400 to update your address. Your check will be mailed to the address on file with ICMA-RC.

Part B: Request for Reimbursement of Non-Recurring Expenses

Use this section to request a reimbursement of non-recurring expenses (e.g., co-payments, medications, out-of-pocket expenses).

Summary of Healthcare Expenses

Incurred Date*	Applicant's Full Name (last, first, middle initial)	Provider (e.g. doctor name/pharmacy name)	Claim for (self, spouse, dependent child, other dependent)	Description of Service	Amount to be Reimbursed
					$
					$
					$

** Incurred date is the date of service, not the billing or payment date.*

Total reimbursement request: $

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature _____ **Date** _____

VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
BENEFITS REIMBURSEMENT REQUEST FORM - Page 2 of 2

Participant Name (Last, First, and Middle Initial) _____

Reference Code _____

Part B: Request for Reimbursement of Recurring Expenses

Use this section to request automated reimbursement of recurring expenses (e.g. insurance premiums). **Note:** Payment must be made to the account holder. Payment will **not** be made directly to an insurance company or other third party.

You are responsible for ensuring automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Supporting documentation must show the premium is paid with after-tax funds and include the following: (i) Insurance Carrier; (ii) Type of Insurance; (iii) Policy Holder's Name; (iv) Amount; and (v) Coverage Period. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

1. ☐ **BEGIN** recurring reimbursement of $_____

Beginning Date: Insert date you wish payments to begin ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

Frequency (Check one): ☐ Annual ☐ Quarterly ☐ Monthly

Ending Date: Insert date of last payment ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

2. ☐ **CHANGE** recurring payment amount from $_____ to $_____

Effective date of change ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

3. ☐ **END** recurring payment of $_____

Ending Date: Insert date of last payment ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

Note: Payments will continue until your account is depleted, unless an ending date is provided. Any changes to your payment must be received by Meritain Health at least 10 business days prior to next payment. Otherwise the change will take effect on the next scheduled reimbursement.

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes, including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature _____ **Date** _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

Send completed form to: VantageCare Retirement Health Savings (RHS) Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611 • 888-587-9441

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