University of Nebraska

Clear Form

REIMBURSEMENT ACCOUNT CLAIM FORM

Additional information regarding dependent and claim eligibility may be found at www.nebraska.edu/benefits.

Claim filing instructions are located on reverse side of this form.

Part A. Employee Information

Name _____ Personnel Number __ __ __ __ __ __
Last First MI (located on pay advice)

Campus Phone _____ Campus Address _____ Campus Zip Code _____

Payroll Cycle: Biweekly ☐ Monthly ☐

Part B. Health Care Claim Information

Date of Service mm/dd/yy	Patient Name	Relationship to You	Name of Provider	Specify condition related to over-the-counter item	Amount Requested
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
___/___/___					
				Total Health Care Amount Requested	**$**

Part C. Dependent Day Care Claim Information

Date of Service	Dependent Name	Age	Care Provider's Name	Provider Tax ID or Social Security #	Amount Requested
				Total Dependent Day Care Amount Requested	**$**

I request reimbursement for the expenses listed above. I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under the university's Reimbursement Account with respect to such expenses and the expenses have not been reimbursed and reimbursement will not be sought from any other source. **In order to receive reimbursement for health and dependent day care claims incurred by a dependent, I certify that my dependent(s) satisfy the eligibility requirements as stated on the university's benefits Web page at www.nebraska.edu/benefits**. I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. I understand that I cannot claim expenses reimbursed under this plan on my personal income tax return. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

_____ _____

Employee Signature Date

UNL 472-2600
32 Canfield, 0409

UNMC 559-5911
985470 NE Medical Center, 5470

UNO 554-3660
205 Eppley Adm

UNK 865-8522
1200 Founders Hall

UNCA 472-2600
32 Canfield, 0409

REIMBURSEMENT ACCOUNT CLAIM FILING INSTRUCTIONS

Additional claim forms are available on the University of Nebraska benefits web page at **www.nebraska.edu/benefits**.

Employee Information: Complete Part A.

Health Care Claim Information: Complete Part B by listing the date of service, patient name, patient relationship to you, provider name, condition for which the over-the-counter item was purchased (if applicable), and the amount not paid by the insurance company for each health care expense. Dependent and claim eligibility requirements are located on the University of Nebraska benefits Web page at **www.nebraska.edu/benefits**. Note: expenses related to cosmetic services including dental bleaching or cosmetic surgery are excluded.

The following documentation should be attached to the completed claim form:

If you have medical or dental insurance, all expenses must be submitted to your insurance company before being submitted for reimbursement. When you receive the Explanation of Benefits (EOB) statement from your insurance company, submit a copy along with the completed claim form. (Do not attach bills.) If you or a covered dependent are covered by two insurance plans, attach EOBs from both insurance plans to claim the amount not paid by either plan. ***If you have vision insurance***, reimbursement of vision care services requires an EOB or detailed/itemized statement noting the amount insurance paid, if any, and your out-of-pocket expense.

If you do not have insurance coverage, submit an itemized statement from the provider showing the date of service, patient name, patient relationship to you, provider name and address, description of service, and the amount charged along with the completed claim form. In addition, you must note on the itemized statement that you do not have insurance coverage. Canceled checks, credit card receipts, billing statements showing "previous balance" or "received on account" are not acceptable.

Prescription drug reimbursement requires, in addition to the Reimbursement Account Claim Form, pharmacy-provided documentation of proof of expense must include the 1) name of the drug or prescription Rx number, 2) date of service, 3) amount paid, and 4) for whom the prescription was dispensed.

Over-the-counter (OTC) medicines and drugs require additional documentation for reimbursement. The receipt or documentation from the store must be legible and include the name of the drug printed on the receipt, date of purchase, and amount paid. In addition, the covered person's name for which the OTC drug was purchased must be noted on the receipt and/or claim form. The claim form must also indicate the existing or imminent medical condition for each OTC medicine or drug. Purchases for general good health will not be accepted.

Some OTC drugs have dual purposes, those purchased to alleviate or treat sickness, pain, and injury while at the same time used for personal/cosmetic or general health reasons. To receive reimbursement, **you must submit the "Letter of Medical Necessity for Dual Purpose OTC Drugs" form** which has been completed by your attending physician**.** To expedite payment, this form should be attached to your submitted claim form. You must renew this notice at the beginning of each calendar year (January 1st) and submit to your Campus Benefits Office.

Dependent Day Care Claim Information: Complete Part C by listing the date of service, dependent name, dependent age, care provider's name, provider's Tax ID or Social Security Number, and amount of the dependent day care expense. Dependent and claim eligibility requirements are located on the University of Nebraska benefits Web page at **www.nebraska.edu/benefits**.

Reimbursement Guidelines: Claims for **both health care and OTC drugs** must equal at least $25 per submission in order to be processed. Any claim submitted that is less than the $25 minimum will be returned to you for future submission. Claims for any dollar amount will be processed for reimbursement in January, February, and March following the end of the plan year.

The IRS only allows a "reasonable limit" of OTC drugs to be reimbursed. The university has defined "reasonable limit" as: a) two packages or bottles, etc. or b) a reasonable supply corresponding to a 90-day supply. A claim submission of three (3) or more OTC drugs for the same or similar general category may be returned to you for clarification or documentation.

All **dependent day care expenses** must be submitted to your Campus Benefits Office for reimbursement by **March 31st**, following the year in which the expense was incurred. **After March 31st, any remaining unreimbursed amounts will be forfeited.**

All **health care expenses** must be submitted to your Campus Benefits Office for reimbursement by **March 31st**, following the year in which the expense was incurred. **After March 31st, any remaining unreimbursed amounts will be forfeited.**

If you are unsure of an expense, please refer to the list of eligible expenses on our website. Heath care expenses must meet requirements of Section 125 and Publication 502 and not all expenses listed Publication 502 are eligible for reimbursement. Dependent care expenses must meet requirements of Section 125 and Publication 503.

Read the certification statement and the dependent and claim eligibility requirements (located on the University of Nebraska benefits Web page at www.nebraska.edu/benefits) carefully. Please sign and date the claim form and forward with supporting documentation to your Campus Benefits Office. A copy of this claim form and supporting documentation should be kept for your records.