



MEDICAL CARE EXPENSE CLAIM FORM

Social Security No.: _____

Participant's Name: _____
Last
First
Middle

Campus Name: _____

The undersigned participant in the Plan requests reimbursement in the amounts shown below: (If additional space is needed, please use an additional claim form.)

MEDICAL CARE EXPENSES

Date Incurred	Name of Service Provider	General Description of Expense	Person for Whom Expense Incurred	Net Amount
				\$
				\$
				\$
				\$
				\$

Total amount of medical expenses claimed. \$ _____

CLAIM IS NOT BEING REIMBURSED BY INSURANCE

NOTE: Federal law requires that you *submit a written statement from an independent third party* (such as an itemized bill from the benefit provider) to be reimbursed for your expenses. Also, you will not be entitled to claim this expense as a tax deduction.

READ CAREFULLY: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the **Choices: The Montana University System's Flexible Benefit Program** with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim that is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee's Signature

Date

Adequately documented claims will be processed within three working days of receipt.

Claims may be sent to: FlexConnect, P.O. Box 2019, Helena, MT 59624
 Contact us at: Phone: (406) 442-3539 or (866) 640-3539 - Fax: (406) 495-3669
 Visit our Website at www.insurancecoordinators.com

How to Fill Out a Claim

1. **Gather your Itemized Receipts or Explanation of Benefits (EOB).**
2. **Make copies for us. You keep the originals! (note: you need to keep your receipts as long as you would keep your tax returns – 7 years).**
3. **Fill out the claim form with all Blanks being filled.**
4. **Sign Your Form.**
5. **Fax or Mail your Claim to Flex Connect.**
6. **Always include your phone number so we can call if we have questions with your claim.**
7. **If you fax your claim, don't highlight the items.**

Definitions:

Itemized Receipts.

Who is the receipt from? *Pharmacy, Doctor Office, Chiropractor, Wal-Mart.*

Date of Service or Purchase.

Itemization of the Product or Procedure. *Some clinics use Codes and that is fine.*

Explanation of Benefits are also referred to as EOBs.

This is perfect! It has all the information required.

Who.

Date of Service

Amount not paid by Insurance.

Itemization of Procedure.

What typically gets a claim denied?

Balance forward bills.

Lack of prescription.

Credit Card Receipts.

Anything without an itemization.

If you have questions please don't hesitate to call or email our Flex Staff.

flex@icmont.com

1.866.640.3539(FLEX) or 406.442.3539(FLEX)