Wellness Incentive Account Reimbursement Request

ECHS Category – HLRR

See instructions on the next page. ☐ 1st Submission ☐ Adjustment ☐ Appeal

Enrollee Information (Please Print Clearly)		
Participant Name (Last, First, MI)		
MHBP ID Number	Daytime Phone	
Address		
City	State	ZIP Code

Health Care Expenses (See instructions on reverse)						
Patient's Name	**Date(s) of Service** From	To	**Type of Service** (i.e., copays, deductible, coinsurance, member responsibility)	**Provider Name** (i.e., physician, hospital, dentist, pharmacy)	**Do you have other coverage for this service?** (Attach EOB)	**Amount of Expense to be Reimbursed**
1.					☐ Yes ☐ No	
2.					☐ Yes ☐ No	
3.					☐ Yes ☐ No	
4.					☐ Yes ☐ No	
5.					☐ Yes ☐ No	
6.					☐ Yes ☐ No	
7.					☐ Yes ☐ No	
8.					☐ Yes ☐ No	
9.					☐ Yes ☐ No	
10.					☐ Yes ☐ No	
					Total amount of reimbursement requested:	**0.00**

By my signature below, I certify that:

- The information given on this reimbursement form is complete and correct.
- I have not received reimbursement for these expenses from the reimbursement account or from any other source.
- All health care expenses listed above comply with requirements and guidelines listed on page 2 of this form.

This authorizes MHBP and my hospital, physician, or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

Enrollee Signature (If submitted without signature, claim(s) will be denied)	Date (MM/DD/YYYY)

Mail this completed form to:
MHBP, PO Box 981106, El Paso, TX 79998-11062

MHBP | aetna

Instructions:

1. **Complete the Enrollee Information section** (please print).
2. **Complete the Health Care Expenses section**. Service must be incurred before being reimbursed.
3. **Attach all required supporting documentation** each time you are requesting reimbursement. Please submit copies, not the originals, as these documents will not be returned.

   Supporting Documentation: The type of documentation described under either A or B below must be attached to the completed form.

   A. Explanation of Benefits form (EOB): This is the form you receive each time you or a health care provider submit claims for payment to your health, dental, or vision care plan. The EOB will show the amount of expenses paid or denied by the plan and the amount you must pay. For all health care expenses that are partially covered by your (or your spouse's) health, dental, or vision care plans, you must attach an EOB. Please do NOT highlight items.

   B. All other Expenses: For expenses not covered at all by your (or your spouse's) health, dental, or vision care plans, reimbursement request will not be processed without acceptable evidence of your expenses. A canceled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain all of the following information (please do NOT highlight items):

   - Name of person for whom the service/supply was provided;
   - Date expense was incurred;
   - Description of service provided (i.e., Office Visit, Dental cleaning, Vision exam, or RX including RX number, NDC, or drug name,);
   - Name of provider (i.e., the physician, hospital, dentist, pharmacy); and
   - Amount of expense(s)

4. Over-the-counter (OTC) medicines or drugs are eligible for reimbursement. The OTC item must include Patient Name, RX Number, NDC Code or Drug Name, Date(s) of Service and Amount.
5. **Sign and Date the form** (we cannot honor reimbursement requests without the enrollee's signature).
6. **Mail the completed form and attachment(s)** to:

   MHBP, PO Box 981106, El Paso, TX, 79998-1106
7. If you have any questions regarding your request for reimbursement, please call **MHBP Customer Service at 1-833-497-2416 (TTY: 711)**.

General Reimbursement Guidelines:

- Reimbursement is not a guarantee that this payment is tax-free.
- Health care expenses reimbursed through this account cannot be deducted on your federal income tax return.
- Expenses can only be submitted for reimbursement if they were for you or for eligible individuals under this Program.
- Reimbursement will only be made in accordance with the provisions of the Program. You accept responsibility for the proper treatment of benefits paid under this Program with respect to eligibility, income tax reporting and liability.
- Requests for reimbursement, including all appropriate supporting documentation, must be received no later than December 31 of the year following the year in which the expense was incurred.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude, or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation, or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 1-800-648-7817, TTY: 711,
Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697** (TDD).

(TTY: 711)

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	**برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.**
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.