How to fill out your Humana Access spending account reimbursement claim form

If you still have questions after you have read these instructions call Customer Care at 1-800-604-6228.

Use this form only to request reimbursement for qualified expenses from your spending account. Do not use this form to verify Humana Access® Mastercard® card swipe(s). For card swipe verification, please go to HumanaAccess.com and register or login; go to the "Claims" tab and click on "Claim Activity." Card swipes (labeled Card) and manual reimbursements will be listed. The transactions needing verification will be marked yellow for Action Needed. You will have two ways to attach documentation to verify the transactions: "Browse" or "Drag and Drop."

Claim submission: Please do not submit expenses for multiple plan years on the same form; submit them separately with a separate cover sheet. Do not use a highlighter on receipts, any part of the form or documentation as this will make it illegible to read and process.

- **Fax submission** - To help us process your claim payment quickly, please fax the completed and signed reimbursement claim form, along with all documentation to: **1-800-905-1851**.
- **Mail submission** - Please mail the completed and signed reimbursement claim form along with all supporting documentation to: **Humana Spending Account Administration, P.O. Box 14167, Lexington, KY 40512-4167.**
- **E-mail submission** - You can also e-mail your documentation to **SpendingAccountSubmissions@humana.com***

  * *While Humana can receive your documentation via email, this is not a secure channel to send personal information. By sending an email, you are accepting the risk that your information may be compromised. For optimal security, please fax or mail your documentation to Humana.*

Please read these instructions before completing the information requested on the spending account reimbursement claim form. You must provide all necessary information or your claim may not be paid.

Part I – Subscriber information: Complete all areas of "Subscriber information." Please type or print as clearly as possible.

Part II – Reimbursement request: Check or complete the appropriate boxes. All healthcare expenses should first be filed under your employer's healthcare plan, or any other coverage you may have, before you request reimbursement from your spending account.

This form is to be used only to request reimbursement for:

- Allowable expenses not fully paid or reimbursed by any other benefit plans (e.g. co-pays, coinsurance, out of pocket). Please attach a copy of the plan's Explanation of Benefits (EOB) as documentation.
- Expenses not allowed by your healthcare plan. Please attach itemized bills or receipts that show the name and address of the provider of the service.

EOB statement: This is the statement you receive each time you or a healthcare provider submits medical, dental, or vision claims to your plan for payment. The EOB will show the amount of expenses paid by the plan and the amount you must pay (member responsibility).

Supporting documentation – Healthcare expenses

In addition to filling out this form, you must attach acceptable documentation. Some plans require an EOB. If this expense was not covered by your insurance carrier, we will accept an itemized receipt. If you have an EOB for this expense, you must send it with this form, or your claim may not be paid.

For expenses not covered by your (or your dependent's) medical, dental, or vision plans, reimbursement requests will not be processed without acceptable documentation. Canceled checks and credit card receipts are not acceptable documentation. Acceptable documentation includes itemized receipts containing the following information:

- Type of service or product provided
- Date expense was incurred
- Name of subscriber or dependent for whom the service/product was provided
- Person or organization providing the service/product
- Amount of expense

Some OTC drugs and medications require a prescription in order to be eligible for reimbursement from your healthcare spending account. A prescription must be included with each reimbursement request.

Part III - Dependent care expenses: Check or complete the appropriate boxes.

Services provided by a childcare or elder care center must comply with all state and local laws to be eligible for reimbursement. The following rules apply to dependent care expenses:

- The claimed expenses must be for the care of a child under age 13 or other dependents that are physically or mentally incapable of caring for self.
- These expenses must be incurred so that you (and your spouse, if married), can work, or your spouse can attend school full-time.
- Provider of services cannot be under the age of 19 and claimed as a dependent on your taxes.
- Dependent care expenses will not be reimbursed until the end-date of service has passed.

Supporting documentation – Dependent care expenses:

- For allowable dependent care expenses, attach a copy of the receipt with dates of service, or have the provider complete and sign Part III "Dependent care expenses."

Part IV – Orthodontia expenses: If you request automatic orthodontia payment reimbursement, it will continue until your contract ends, your spending account funds are exhausted or you cancel.

Part V – Subscriber certification for reimbursement: Please read, sign and date to validate the entire claim form.

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Humana Access spending account reimbursement claim form

Part I: Subscriber information (Please print)

Subscriber name (Last/First/MI)	Date of birth	Member ID or Social Security Number
Subscriber email address (to receive your spending account correspondence via email		Daytime telephone #

Part II: Reimbursement request

Claim type Combine all of the same type(s) of expenses on the same line.	Dates of service		What type of documentation is included for this expense? (check one or both)		Total amount requested
	Beginning date	Ending date	*Explanation of Benefits (EOB)	Itemized receipt	
Preventive care					
Medical					
Vision					
Prescription					
Over-the-counter medication (OTC)					
Dental					
Durable medical equipment					
Other					
				Total amount requested:	

***Some plans require an EOB in order to be reimbursed from your spending account. If this expense was not covered by your insurance, we will accept an itemized receipt.**

Part III: Dependent care expenses

	Dependent's full name	Date of birth	Dates of service		Amount requested	Adult	Disabled	Daycare
			Beginning date	Ending date				
1								
2								
3								
				Total amount requested:				

Provider Tax ID: (Optional)		Provider name:

I provided adult/childcare services to the above individual(s) for the amounts and dates that are listed above:

Please note: This signature line is for the provider of dependent care services only - Subscriber should sign on line at bottom of page for the entire claim form.

Dependent Care Provider signature: X _____ **Date: X** _____

Part IV: Orthodontia Expenses

	Automatic Monthly Reimbursement for Orthodontia expenses: To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. Note: For automatic monthly reimbursements, you only need to send this form and the contract once.
	Cancel Monthly Reimbursement for Orthodontia expenses

Part V: Subscriber certification for reimbursement - I hereby certify that:

- The above information is correct
- I have not received and will not seek reimbursement for these expenses from any other plan, including through the use of my Humana Access card
- These expenses are not eligible for reimbursement under any other plan
- I understand that reimbursement is not a guarantee that this payment is tax-free
- Healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return
- Dependent care expenses reimbursed through this account cannot be used as a dependent care credit on my personal tax return

I allow Humana, or its representative, to validate the supporting documentation I have provided (attached to this document) with doctors, hospitals, medical service providers, pharmacists, employers, and other agencies or organizations (including other insurers) to confirm these expenses are allowed under this plan and IRS guidelines.

Subscriber (your) signature: X _____ **Date: X** _____

To expedite claim payment please fill out this claim form completely and provide supporting documentation.

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