Claim Form

emeriti RETIREMENT HEALTH

Skip the form!

Log into your Emeriti RHSP online account at **MyEmeritiHealth.org**, or the **HRAgo® mobile app** to submit your claim and your supporting documentation online. To submit this paper form, follow instructions provided below and send to: **Emeriti RHSP, PO Box 4391, Clinton, IA 52733-4391.**

1 Participant Information (Please fill out your information below.)

Participant Number or SSN: ____________________ Date of Birth: ____________

First Name: ____________________ Last Name: ____________________

Address: ____________________ Is this a new address?

City: ____________ State: ________ Zip Code: ________

Phone Number: ____________ Email Address: ____________________

2 Required Supporting Documentation

Please provide copies of documentation for expenses that are eligible for reimbursement. Certain expenses may require a Letter of Medical Necessity from your doctor. Please ensure that your documentation is legible (no highlighting) and contains the following five items:

1. **Provider Name**
2. **Patient Name**
3. **Date of service**
4. **Description of service or item (Canceled checks, balance forward statements, and credit card receipts are NOT acceptable).**
5. **Amount incurred by Patient**

3 Expense Information

Covered Individual	Date of Service	Expense Amount
Self Spouse Domestic Partner* Dependent Spouse/Dependent Name: ____________ SSN: ____________ DOB: ____________		
Self Spouse Domestic Partner* Dependent Spouse/Dependent Name: ____________ SSN: ____________ DOB: ____________		
Self Spouse Domestic Partner* Dependent Spouse/Dependent Name: ____________ SSN: ____________ DOB: ____________		

* Your ability to add a domestic partner as a Covered Individual depends on the terms and conditions of your employer's RHSP plan. To add a domestic partner, you must complete and submit a Domestic Partner form, which is available under the **Resources** tab on your online portal account at **MyEmeritiHealth.org**. A claim submitted for a domestic partner who has not been added using the Domestic Partner form will be denied.

4 Required Participant Authorization and Certification

By completing and submitting this form, you agree to the terms and conditions of your employer's RHSP plan and certify that: (1) all information provided in this submitted claim is true and correct; (2) the amount of this submitted claim is an accurate statement of your (a) unreimbursed medical/dental/vision expenses after payment by insurance (if any) and/or (b) medical/dental/vision/tax- qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source.

Covered Individuals: With respect to claims submitted on behalf of Covered Individuals, you also certify that each individual meets the Plan requirements under the terms of the Plan..

Questions? 1-866-EMERITI (1-866-363-7484)