Personal Account Plan Reimbursement Form

Send your claim form and itemized receipts to request reimbursement to:
POMCO
2425 James Street
Syracuse, NY 13206 or
Fax to 315.703.4880

SECTION 1: Enrollee Information. If you are submitting expenses for more than one calendar year, you must submit a separate form for each year.		
Last Name:	First Name:	Social Security Number:
Street Address/P.O. Box:	City and State:	Zip Code:

SECTION 2: Health Expense Information. Please attach the appropriate documentation for each claim. See back for documentation details including information on submitting orthodontia claims. Please note the claim filing deadline is 11 months from the date of service.

Patient Name:	**Date of Birth:**	**Relationship to Enrollee:**	**Dates of Service From-To:**	**Reimbursement Request:**
Total Personal Account Plan Reimbursement Request Amount:				

SECTION 3: Coordination of Benefits.

Are you or any of the above-listed family members eligible to receive benefits under any medical, dental, prescription, or vision plan other than your primary health plan?
_____ Yes (include copies of EOBs from each of the applicable) _____ No

I certify that the expenses for which I am seeking reimbursement from the CNY Laborers' Personal Account Plan have been incurred by me, or by an individual who qualifies as my spouse or my dependent under IRS guidelines. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including o Health Savings Account (HSA). I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law, and that I am solely responsible for any tax reporting and other legal requirements with respect to reimbursements under my plan. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement. Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

Employee Signature:	Date:

<u>**Instructions for Submitting Your Claim and Preparing Your Claim Form**</u>

SECTION 1. Enrollee Information. Your social security number is your Personal Account Plan identification number. You must report address changes to your employer. Your employer must notify POMCO of your new address to avoid payment delays.

SECTION 2. Health Expense Information. List health expenses for each family member. To avoid payment delays, **you must attach the appropriate documentation for each claim.** Note: Under IRS rules, credit card receipts or canceled checks are not adequate documentation. Proper documentation examples are listed in the chart below:

If the expense is partially covered by insurance or other coverage or if your insurance or other plan does not cover this expense at all:	**For prescription drug claims or if you do not have any other coverage:**
Submit the Explanation of Benefits (EOB) with your completed form. Unless additional documentation is requested, you do not need to submit any other documentation with the EOB. For a prescription drug claim, please see the instructions to the right. NOTE: You should only submit this claim form once you have received a final EOB which shows that the insurance of the other plan has paid its portion of the claim.	Submit the itemized receipt or statement from the health care provider (e.g. doctor, dentist, pharmacy). This itemized receipt or statement must include: • Name and address of the health care provider • Patient's name • Date(s) of service • Type of service • Dollar amount charged NOTE: A receipt from the health care provider must show the patient's financial responsibility.

Orthodontia Expenses.
To be reimbursed for orthodontia expenses, you must actively be employed (or participating through COBRA). For orthodontia claims, please follow these guidelines:

1. Your first claim submission (including lump sum payments in full) must include treatment plan (orthodontia contract) from the orthodontist along with the signed Reimbursement Request form. The treatment plan must show:
    a. The patient's name
    b. The beginning and ending date of treatment
    c. The total contracted amount
    d. The initial payment amount (or total lump sum paid and discount applied, if any)
    e. Any estimated payment by insurance or other coverage
2. Each monthly request for reimbursement thereafter must include a completed and signed Reimbursement Request form along with an itemized bill/receipt or payment coupon from the orthodontist. This bill must show that the scheduled monthly payment is consistent with the original contract.
3. No reimbursements will be allowed in future plan years. You will need to follow the procedures above at the beginning of the next plan year if you wish to continue reimbursements.

SECTION 3. Coordination of Benefits (COB). When an expense is covered under more than one plan (insurance or otherwise), both Explanation of Benefits (EOB) must be submitted in order to process the claim.

SECTION 4. Employee's Certification for Reimbursement. To avoid payment delays, you must sign and date this form.