Horizon

Horizon Blue Cross Blue Shield of New Jersey

Horizon *MyWay*℠

PO Box 1369
Newark, NJ 07101-1369
Phone: (800) 224-4426 Fax: 973-274-4185
www.HorizonMyWay.com

CLAIM FOR REIMBURSEMENT

Company Name _____ ID # _____

Your Name _____ Phone # _____

Home Address _____ City _____State _____ Zip _____

☐ Check here if new address

DEPENDENT CARE (DAYCARE) EXPENSE CLAIMS					
Name of Dependent(s)	Period Covered		Name and Address of Provider of Service	Taxpayer ID or Member ID	Amount Incurred
	From	To			

UNREIMBURSED MEDICAL EXPENSE CLAIMS					
Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount	*No Ins. Coverage (Initial)
			Total Medical Care Expenses Claimed		

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 company Flexible Spending Account Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that (s)he alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which 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 payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

*No insurance coverage for expense - please initial.

_____ _____

Employee's Signature Date

READ CAREFULLY

CLAIM FILING INSTRUCTIONS

Who files a claim form?

- Only employees participating in the company Flexible Spending Account Plan can file a reimbursement claim form.
- Employees can file a claim for during the plan year and for a certain period after the plan year as described in the Summary Plan Description.
- Terminated employees can file a claim form for a certain period after the date of termination if allowed by the plan. **Please see your Summary Plan Description.**

Qualifying dependent care expenses

- Expenses paid to a dependent day care center or care provider.
- Expenses paid for the care of a dependent under age 13.
- Expenses paid for care of other dependent(s) who are physically or mentally incapable of caring for themselves.

Qualifying unreimbursed medical expenses

- You can only claim expenses not reimbursed by insurance, including:

DENTAL SERVICES
Crowns/bridges
Dental x-rays
Dentures
Exams/teeth cleaning
Extractions
Fillings
Gum treatment
Oral surgery
Orthodontia/braces

INSURANCE-RELATED ITEMS
Preexisting condition expenses (medical)
Private hospital room differential

LAB EXAMS/TESTS
Blood tests
Cardiographs
Diagnostic
Laboratory fees
Metabolism tests
Spinal fluid tests
Urine/stool analyses
X-rays

MEDICATION
Insulin
Over-the-counter medicine
(to treat illness or medical condition)
Prescribed birth control
Prescribed vitamins
(to treat specific disease & not available over-the-counter)
Prescription drugs*

OBSTETRIC SERVICES
Mid-wife expenses
OB/GYN exams
OB/GYN prepaid maternity fees
(reimbursable after date of birth)
Post-natal treatment
Pre-natal treatment
Prescribed pre-natal vitamins

PRACTITIONERS
Allergist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Osteopath
Physician
Psychiatrist
Psychologist

OTHER MEDICAL TREATMENTS/PROCEDURES
Acupuncture
Alcoholism (inpatient treatment)
Bio-feedback therapy
(in medically necessary situations)
Cosmetic surgery
(if medically necessary due to a congenital defect)
Drug addiction
Hearing exams
Hospital services
Infertility
In-vitro fertilization
Norplant insertion or removal
Patterning exercises
Physical examination
(not employment related)
Physical therapy
Speech therapy
Sterilization
Transplants (includes organ donor)
Vaccinations/immunizations
Vasectomy and vasectomy reversal
Well baby care

OTHER MEDICAL EQUIPMENT, SUPPLIES and SERVICES
Abdominal/back supports
Ambulance services
Arches/orthopedic shoes
Contraceptives, prescribed
Counseling
Crutches
Guide dog (for visually/hearing impaired person)
hearing aids & batteries
Hospital bed
Learning disability
(special school/teacher)
Lead paint
(if not capital expense, and incurred for a child poisoned)
Medic alert bracelet or necklace
Oxygen equipment
Prescribed medical and exercise equipment
Prosthesis
Splints/casts
Support hose (if medically necessary)
Syringes
Transportation expenses (essential to medical care)
Tuition fee at special school for disabled child
Wheelchair
Wigs (hair loss due to disease)

VISION SERVICES
Artificial eyes
Contact lenses
Contact lens solution
Eye examinations
Eyeglasses
Laser eye surgeries
Ophthalmologist
Optometrist
Prescription sunglasses
Radial keratotomy/LASIK

Completing the claim form

- Complete **all** information on the claim form for each amount claimed for reimbursement.
- **You must sign and date the claim form.**
- Attach copies of bills, invoices or other written statements from a third party that support each reimbursement request and mail or fax to:

NJ CDH
PO Box 1369
Newark, NJ 07101-1369

Fax: **973-274-4185**

Web site: **www.HorizonMyWay.com**