EMPOWER®

##63T02652##################

Medical Reimbursement Claim Form

Fax completed form to:
321.445.9618

Mail completed form to:
Empower CDH
P.O. Box 161588
Questions
855-375-3050

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EMPLOYEE INFORMATION (Please Print)			
EMPLOYER/PLAN SPONSOR **MERS**	FIRST NAME	MI	LAST NAME
ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP	
PHONE	LAST 4 DIGITS OF SSN		EMAIL ADDRESS

MEDICAL REIMBURSEMENT EXPENSE CLAIMS				
DATE	SERVICE	PATIENT NAME	SELECT ONE	AMOUNT
			Reimburse ☐ Used Card ☐	$
			Reimburse ☐ Used Card ☐	$
			Reimburse ☐ Used Card ☐	$
			Reimburse ☐ Used Card ☐	$
			Reimburse ☐ Used Card ☐	$
			Reimburse ☐ Used Card ☐	$
			Reimburse ☐ Used Card ☐	$
			Reimburse ☐ Used Card ☐	$

PARTICIPANT SIGNATURE (REQUIRED)

I certify that this claim submission is accurate, complete, and eligible for reimbursement to the best of my knowledge. I certify that I have not been reimbursed or expect to be reimbursed by any other source. Additionally, I understand I must submit documentation to support my submission to receive reimbursement.

PARTICIPANT SIGNATURE: _____

DATE: _____

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SUBMISSION GUIDELINES

Please follow these guidelines to ensure that your claims are reimbursed quickly. Failure to attach the proper documentation may result in a declined or rejected claim.

Acceptable Documentation

- Itemized receipt that shows the date of service, type of service received, provider name, patient name, amounts paid by the insurance, and amount owed
- Explanation of Benefits (EOB) from insurance company
- Pharmacy receipt or statement that includes the RX number and name of the drug
- Detailed cash register receipt listing of all eligible over-the-counter items only

Unacceptable Documentation

- Canceled checks
- Debit card or credit card receipts
- Balance forward or previous balance statements
- Paid on account statements
- Pre-payments for future services
- Services incurred prior to your eligibility date for medical reimbursement
- Insurance estimates

Orthodontia

You must submit an orthodontic contract showing treatment start and end dates, the amount of the initial payment and the number of and amount of monthly payments.

Alternative Treatments

Expenses that may be seen as merely beneficial to general health will require a Letter of Medical Necessity (LMN), showing the treatment of a specified medical diagnosis. Examples include vitamins/supplements, herbs, weight loss programs, cosmetic products and procedures. Please have your provider write a letter and attach to your claim.

Get Reimbursed Faster

File a claim and sign up for Direct Deposit using your online or mobile experience.

Online & Mobile App

Access your account online at **empower.com/MERS** or download the **Empower Benefit Accounts** app from the Apple App Store or Google Play to:

- Manage your debit card and claims profile — personal information, communication preferences, and more
- View your debit card and claims summary — balance, transactions, important dates, and more
- Create new claims, upload receipt documentation, and track the status of your claims
- Enroll to receive claims reimbursement via Direct Deposit