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GUIDELINES FOR SUBMISSION OF SECTION 125 CLAIMS

These guidelines are intended to aid you in filing claims though Section 125 Plan for reimbursement. They will assist you in receiving a quick reimbursement and avoiding an unnecessary return or requests. They are as follows:

Necessary items to include in your packet of Section 125:

1. Fully completed claim form (health or dependent care reimbursement form). These can be obtained by going to the District website (Our District -- Business and Finance -- Employee Section)

2. Explanation of benefits from either your medical or dental insurance. This is the paper that is attached to your insurance payment. This can also be obtained from your individual medical or dental care giver. Most medical and dental insurance will send you and your primary care provider a copy of the benefits. The E.O.B. contains all the information needed to process your out of pocket expenses (i.e.: name of patient, date of service, name of doctor). If your insurance does not cover a particular procedure or the fee has been applied to your deductible, we must have the denial or the statement stating such facts (an itemized bill stating these facts is NOT ACCEPTABLE). If you do not have or cannot obtain an E.O.B. for co-payments reimbursement, then you must submit the following:

   A. An itemized bill from the primary care provider giving details of all services that were rendered to total the amount being submitted in for reimbursement. This bill must list the dates of services, the procedures performed, names of patient, name of doctor AND any insurance payments that were made on the account. Without this information, an itemized bill is NOT ACCEPTABLE. "Balance Forward" and "Previous Balance" statements are NOT ACCEPTABLE. If you DO NOT have insurance, this also must be stated on the itemized bill.

   B. Written receipts from a doctor's office are acceptable as long as the actual date of service (not the date you paid), the name of the patient and the name of the doctor is clearly printed on the receipt. These receipts can only be the usual copayment amount that you would normally pay for your visit (i.e.: $10, $15, or $20). If it is an out of the norm amount, then either an itemized bill or an E.O.B. is necessary to ensure reimbursement.

   Cancelled checks are also NOT ACCEPTABLE; they do not specify the information needed to properly process your claim.

Predeterminations of Benefits are NOT ACCEPTABLE for reimbursement under the Flexible spending account program. A predetermination of benefits is an estimate of payment prior to services being performed. Reimbursement can only be given for date of services that were actually performed.

C. Prescription: If you are submitting receipts for pharmacy co-pays, please send in the pharmacy receipts that you receive attached to the prescription. These receipts detail the name of patient, date when the prescription was filled; co-payment amount and prescription number that we need to process the claim. Register receipts are only acceptable for the purchase of over-the-counter drugs. **The cash register receipt must have the name of the OTC drug and the date of service along with the physician prescription**. If you cannot collect all these receipts or you may not have saved them, your pharmacist can print out a list of your entire family's history of prescriptions for that particular year. Privacy may be a concern; therefore, you may block out any names for medication to ensure your privacy.

Sending in a complete and clearly legible claim to our office will ensure a quick reimbursement. As always, we are happy to assist you in any matters or concerns that you may have. Please contact us at 516 944-2823.