RESET

Horizon Blue Cross Blue Shield of New Jersey

MERCK

Horizon BCBSNJ FSA
P.O. Box 829
Newark, NJ 07101-0829
Phone: (877) 663-7258
Fax 973-274-2233
www.HorizonBlue.com/Merckfsa

CLAIM FOR REIMBURSEMENT

Company Name Merck & Co ID # W2046 84271

Your Name Senthil Murugan Phone # (267) 305-6571

Home Address 110 Galway Circle City Chalfont State PA Zip 18914

☐ Check here if new address

DEPENDENT CARE (DAYCARE) FSA CLAIMS

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

HEALTH CARE FSA EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount	*No Ins. Coverage (Initial)
8/5/2016	Pragna P. Patel, M.D., P.C.	Office Visit (Code: 99214)	Ramya Balaram	18.69	
9/9/2016	Pragna P. Patel, M.D., P.C.	Office Visit (Code: 99214)	Ramya Balaram	18.69	
10/20/2016	Pragna P. Patel, M.D., P.C.	Office Visit (Code: 99214)	Ramya Balaram	18.69	
12/16/2016	Pragna P. Patel, M.D., P.C.	Office Visit (Code: 99214)	Ramya Balaram	18.69	
			Total Medical Care Expenses Claimed	74.76	

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.**

Which expenses can I claim?

- You can claim only expenses incurred during the plan year for reimbursement. Each year is treated separately and the year of claim is the year the expense was actually incurred by the participant. You must send separate claim forms for each year.
- Terminated employees can request reimbursement for expenses incurred during the time period for which contributions were received. **Please see your Summary Plan Description.**
- Allowable expenses are the same as those allowed for tax purposes. **See the summary below.**

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:

Ambulance hire
Artificial limbs/teeth
Automobile modifications (hand controls/special equipment/mechanical lifts)
Braille books/magazines
Crutches
Elastic hose, medically prescribed
Eyeglasses/contact lenses/solutions
Eye exam
Fees
Acupuncture
Anesthetist
Blood donor
Chiropractor
Christian Science practitioners
Clinic
Dentist (excluding cosmetic services, i.e., teeth whitening)
Diagnosis
Diathermy
Exam, physical
Gynecologist
Halfway house residency
Healing services
Hearing devices
Hospital bills
LASIK eye surgery
Lip reading lessons for the deaf
Medical
Midwife
Nurse
Obstetrician
Obstetrical expense
Oculist
Operations/related treatments
Ophthalmologist
Optician
Optometrist
Oral surgery
Osteopath
Oxygen equipment
Pediatrician
Physician
Physiotherapist
Podiatrist
Practical nurse
Prescription drugs and medical supplies excluding cosmetic Rx
Psychiatrist
Psychoanalyst
Psychologist
Psychopathist
Rental of medical/healing equipment
Retirement home fees, portion allocable to medical care
Seeing eye dog
Sex therapist
Special education
Specialist
Supportive/corrective devices (including special mattress/board for arthritis)
Surgeon
Telephone for deaf
Television set modifications to receive closed captions
Therapy treatments
Transportation expense relative to illness
X-rays
Wheelchair

Completing the claim form

- Complete **all** information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.
- **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:

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Newark, NJ 07101-0829

Fax: **973-274-2233**

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