luminare health™

Wyandotte Nation
REIMBURSEMENT REQUEST

Phone: 877-267-3359

SEE REVERSE SIDE FOR INSTRUCTIONS

Fax: 866-514-8287

A. EMPLOYEE INFORMATION

Name	Tribal Member Number	Name of Tribe: Wyandotte Nation
Member ID	Phone Number	Email Address

B. Supplemental Health Care Benefit Account

Date(s) of Service	Name of Service Provider	Patient Name	Type of Expense (Office Visit, Dental, Eyeglass, RX, Mileage, etc.)	Amount Requested
			TOTAL AMOUNT REQUESTED	$

C. CERTIFICATION

I certify that the following is true:

1. **The expenses listed above were incurred by me and/or my eligible dependents and qualify for reimbursement within the current plan year. (See reverse side for a description of eligible expenses.)**
2. The expenses listed above are not eligible for reimbursement by any insurance plan.
3. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
4. The appropriate bills, receipts, Explanation of Benefit Statements. **Please keep copies of supporting documentation for your records. Documents will not be returned.**
5. For Over-the-Counter medications to be eligible expenses under the plan, they must be for the diagnosis, prevention or treatment of a specific medical condition and not just for the overall good health of the participant.

****NOTE: If a portion of your medical expense(s) are covered by insurance, please send an Explanation of Benefits (EOB) for verification.**

Employee Signature _____ Date _____

Submit claim(s) electronically:
Portal: myluminarehealth.com (click the Benefit Spending Accounts link to access your account) **Mobile:** Benefit Spending Accounts
Or return this form to:
Benefit Spending Accounts • P.O. Box 2968 • Clinton, IA 52733

Contact
Phone: 877-267-3359 / **Fax:** 866-514-8287 / **Email:** FlexHB@LuminareHealth.com

CLAIM FILING INSTRUCTIONS

1. Please complete the claim form in full and attach copies of all receipts, invoices, or explanation of benefit (EOB) statements. Documentation must clearly indicate the following:
   - Date services incurred or supplies purchased
   - Name and address of the provider of services or supplies
   - Name of the person receiving the service or supply
   - Type of expense
   - Amount of expense
   - Total amount paid by any insurance company

2. If any insurance company did not or will not reimburse you for ANY portion of an expense that you are submitting, please mark across the top of the invoice or receipt “NOT PAID BY INSURANCE” and initial it. If it is an expense which is part of your deductible, a copy of the EOB must be attached.

3. Do not send cancelled checks or statements indicating balance due. These types of receipts do not supply the required documentation.

4. Claims submitted without the necessary information will be returned to you and may cause a significant delay in processing your reimbursement.

5. Keep copies of supporting documentation for your records.

6. You may also file your claim online at myluminarehealth.com or by using our mobile app Benefit Spending Accounts available for free download from the iTunes App Store and Google Play. (***Please note if you submit your claim on-line you do not need to submit the paper form.)

7. T o determine if a specific expense you are claiming qualifies as an eligible expense, please contact Luminare Health at 877-267-3359 or email us at FlexHB@LuminareHealth.com.

8. Minimum check reimbursement amount is $25.00 for claims electronically (portal/mobile app) or manual submitted. Claims submitted not totaling the required check minimum of $25.00 will hold until your claim total reaches $25.00, or account balance is less than $25.00.