MEDICARE REIMBURSEMENT ACCOUNT (MRA) CLAIM FORM INSTRUCTIONS
HOW TO SUBMIT CLAIMS BY FAX OR MAIL

IMPORTANT

Don't include this instruction page with your faxed or mailed claim form.

FILLING OUT YOUR CLAIM FORM

1. Account Holder Information

Please print or write legibly when completing the account holder first and last name. Complete a separate form for your spouse and/or covered dependents.

2. Claims for Out-of-Pocket Expenses

This section should be filled out according to how your Medicare Part B premiums are paid.

Check the first box if your Medicare Part B premium is deducted from your Social Security or Annuity check.

Check the second box if your Medicare Part B premium is not deducted from your Social Security or Annuity check and is paid by you on an after-tax basis.

Your service start date is either January 1 of the year for which you are requesting reimbursement, your effective date if after the first of the year, or the first of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Your service end date is either December 31 of the year for which you are requesting reimbursement or the last day of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

Fill in the total annual or monthly/quarterly amount of your Medicare Part B payment.

3. Proof of Payment

Attach proof of Medicare Part B premium payment.

SELECTING YOUR PROOF OF PAYMENT DOCUMENTS

The Internal Revenue Service (IRS) requires you to provide documents to verify that you paid for a Medicare Part B premium. At a minimum, the document(s) must show:

The date you paid your Medicare premium

The Medicare Part B account holder's name

The name of your insurance carrier (Blue Cross and Blue Shield Service Benefit Plan)

The type of expense (Medicare Part B premium)

Proof of premium payment (such as a cleared check, bank statement, or credit card statement that shows the amount you paid for the Medicare Part B premium)

The Blue Cross® and Blue Shield® words and symbols, Federal Employee Program® and FEP® are all trademarks owned by Blue Cross Blue Shield Association.

MEDICARE REIMBURSEMENT ACCOUNT (MRA)
PAY ME BACK CLAIM FORM

- Print or write legibly.
- Do not use a fax cover sheet.

Submit your completed claim via toll-free fax: (877) 353-9236
OR mail: Claims Administrator, PO Box 14053 Lexington, KY 40512

1 MEMBER INFORMATION

Last Name

First Name

B C B S S E R V I C E B E N E F I T P L A N
Employer Name

ID Code*

Your ID code is a 4-digit combination of your day of birth and the last 2 digits of your SSN. For example, if you were born on the 8th day of the month and the last 2 digits of your SSN are 12, your ID Code would be 0812.

Date of Birth (MM/DD)

Zip Code

2 CLAIMS FOR OUT-OF-POCKET EXPENSES

Check one:

☐ My Medicare premiums are automatically deducted from my Social Security or Annuity check. (Enter annual amount)

☐ I pay my Medicare premiums after-tax. They are not automatically deducted from my Social Security or Annuity check. (Enter monthly/quarterly amount)

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Out-of-Pocket Cost

3 SUBMIT YOUR PROOF OF PAYMENT

Include proof of payment as an attachment to this form that shows you pay Medicare Part B premiums. Remember to keep the originals of the documents you submit.

If you checked the first box in step 2 above, please submit a copy of your Cost of Living Adjustment (COLA) statement or Annuity Statement.

If you checked the second box in step 2 above, please submit a copy of your Medicare Bill along with your proof of payment (such as a cleared check or bank or credit card statement).

Date ______________________

I certify that the information on this form is accurate and complete. I am requesting reimbursement for Medicare Part B premium expenses I incurred while a member of the Blue Cross and Blue Shield Service Benefit Plan. I have not/will not seek reimbursement of this expense from any other plan or party because I:
1) pay for the premiums through withholding, 2) have paid for the premiums out-of-pocket.

Use of this service indicates my acceptance of the WageWorks User Agreement at fepblue.org/mra (available upon registration; enter username and password or click on First Time User).