REQUEST FOR REIMBURSEMENT
CLAIM FORM

Arrow Benefits Group
Complex Questions. Straight Answers.

Employer Name:			
Employee Name:	Last First MI	**SS#**	/ /
Employee Address:	Street City State ZIP	**PHONE**	( )

☐ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* **Information below must be completed**

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
					$
				Total Medical Care:	$

DEPENDENT CARE CLAIMS

Date of Service From	To	Dependent Name	Age	Relationship	Dependent Care Provider Name	Provider Tax Id# or SS#	Claim Amount
							$
							$
							$
							$
						Total Dependent Care:	
						Grand Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, file a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ /_____ /_____

For faster reimbursement, **fax** to: 415-878-0269 or **email** to: MariD@arrowbenefitsgroup.com

Or mail to: **Arrow Benefits Group** • P.O. Box 750578 • Petaluma, CA 94975

PREPARING A CLAIM FOR SUBMISSION

Follow the steps below to prepare a claim for submission. Be sure that you always keep a copy of your claim and receipts for your records before submitting them to The SSM Group.

Complete the account holder's information section located at the top of the form.
Provide the account holder's first and last name, the account holder's full social security number, the account holder's employer, the account holder's home phone number and the account holder's work phone number.

Read the "Certification" section located at the bottom of the form. The account holder should then sign and date the form (in ink).

Complete the appropriate section(s) of the form. If reimbursement for Dependent Care funds is being requested, complete the "Dependent Care Claim Detail" section of the form. If reimbursement for Medical Expense funds is being requested, complete the "Medical Expense Claim Detail" section of the form. You may also complete both sections if submitting reimbursement requests from both accounts.

Provide corresponding documentation for each request. Documentation is required to be submitted with your Claim Form for Reimbursement; if proper documentation is not received with your claim, your request will be denied/delayed. Documentation that does not meet the necessary requirements will be denied/delayed.

Proper documentation for your Dependent Care Account can be a handwritten receipt signed by your dependent care provider. You can also submit a copy of your monthly bill/statement. Documentation submitted for your Dependent Care Account must provide:

- Provider name, address, phone number and Tax ID Number
- Amounts charged
- Date(s) of service

Proper documentation for your Medical Expense Account can be the EOB (Explanation of Benefits) from your insurance carrier, detailed receipt, billing invoice, or statement. Documentation submitted for your Medical Expense Account must provide:

- Provider/Facility name, address and Tax ID Number
- Patient or person receiving the service
- Date of service/date of item purchased
- Service/item description
- Amount charged for service/item

PLEASE NOTE: All services/items must be submitted to insurance (if applicable) whether or not the service/item is a covered benefit per IRS regulations. Check copies and credit card slips do not provide the information necessary to process your request. Claims submitted with check copies and/or credit card slips will be denied/delayed.

You may fax or mail your claim to:

Arrow Benefits Group
P.O. Box 750578
Petaluma, CA 94975
Fax: (415) 878-0269

Checks are printed on a weekly basis. Claims received are typically processed between 3-5 business days.

Under federal HIPAA regulations, be advised that all of the information you provide to us is protected for your privacy. No one other than the claimant may receive or request information for medically-related data without authorization from the claimant. Should you have any questions on our policies or procedures with regard to HIPAA, please call our office. If you have any further questions regarding claim submission, please do not hesitate to contact our office.

Please feel free to contact our office:
(707) 992-3776