PRESBYTERIAN

Connected Care High Deductible Health Plan (HDHP)
Extra Bucks Reimbursement Claim Form

FAXES NOT ACCEPTED.
Please mail this form to:

Presbyterian
P.O. Box 27489
Albuquerque, NM 87125-7489
Attention: Claims – Extra Bucks Reimbursement

If you would like help with this form, contact the Connected Care Customer Service Center at Presbyterian by calling (505) 923-8000 or calling toll-free at 1-855-780-7737, Monday through Friday from 8 a.m. to 6 p.m. TTY users may call 1-877-298-7407.

EMPLOYEE INFORMATION

The employee or primary policy holder must complete this section.

First Name, MI, Last Name		Member ID Number:			
Address (No P.O. Boxes)		City	State	County	ZIP Code
Home Phone	Work / Message Phone	E-mail Address			

EXTRA BUCKS REIMBURSEMENT INSTRUCTIONS

You must complete both sides of this form. Once we receive your completed form, your reimbursement request will be processed within 30 days. We will adjust the reimbursement amount if any part of a receipt cannot be processed for any reason. Incomplete forms or requests submitted on the wrong form will be returned. Keep a copy of the form and all supporting documentation for your records.

1. Review the eligible expense listing and FAQ's. Complete all sections (as appropriate) on the front and back of this reimbursement form.
2. Attach original itemized receipts and required documentation. Tape small receipts to an 8 ½ X 11" piece of paper.
3. Mail this original form with your signature (not copies of the form).

SERVICES RECEIVED (ALSO COMPLETE THE BACK OF THIS FORM.)

Complete the information below for yourself or your legal spouse, domestic partner, or dependent child(ren) who received the service(s) for this claim. Dependent child(ren) must be younger than age 26.

Name (First Name, MI, Last Name)	**Relation**	**Member ID**	**Date of Service**	**Amount**
1.	Self ☐ Spouse ☐ Child ☐			
2.	Self ☐ Spouse ☐ Child ☐			
3.	Self ☐ Spouse ☐ Child ☐			
4.	Self ☐ Spouse ☐ Child ☐			
5.	Self ☐ Spouse ☐ Child ☐			
6.	Self ☐ Spouse ☐ Child ☐			
			TOTAL OF ALL REQUESTS	**$**

I certify that I and/or my eligible dependents have incurred the above expenses.

Signature: _____ **Date:** _____

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A PROVIDER OR PHARMACY RECEIPT MUST BE ATTACHED FOR REIMBURSEMENT TO BE PROCESSED. REFER TO THE PAY, STOCK AND BENEFIT HANDBOOK FOR COVERED BENEFITS. PLEASE BE SURE THAT YOU UNDERSTAND THE TYPES OF EXPENSES THAT ARE ELIGIBLE FOR REIMBURSEMENT BEFORE YOU SUBMIT THIS FORM.

1. You can use your Extra Bucks on qualified expenses **after** your plan deductible is met. To view a comprehensive list of qualified expenses, please visit www.presintel.org, and select Extra Bucks Account Information.

Indicate the type of reimbursement you are requesting, and complete the required information in the first section, for the allowable expenses (after your deductible is met):

	Out-of-pocket costs (coinsurance) for medical covered benefits. Provide a description of the service received below:
	Out-of-pocket expenses (coinsurance) for covered Pharmacy expenses.

2. You can also use your Extra Bucks on the qualified expenses **before** your plan deductible is met. To view a comprehensive list of qualified expenses, please visit www.presintel.org, and select Extra Bucks Account Information

Indicate the type of reimbursement you are requesting, and complete the required information in the first section, for the allowable expenses (before your deductible is met):
