WageWorks®

Health Care Account

Pay Me Back Claim Form

www.hr.duke.edu/benefits/reimbursement

TOLL-FREE FAX: (877) 353 - 9236

Or, mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

DO NOT USE A FAX COVER SHEET
to ensure speedy processing.

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Duke Unique ID* (last 4 digits)

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

* Can't remember your ID? Check back of your ID badge or go to www.hr.duke.edu/benefits/reimbursement.

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. **I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan. (Patient & Relationship is assumed to be Self unless otherwise indicated.)** I have already received these products and services and have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one health care account, reimbursement will be made according to the payment order determined by those plans and as stated on the WageWorks Web Site. Use of this service indicates my acceptance of the WageWorks User Agreement at www.hr.duke.edu/benefits/reimbursement.

Signature of Account Holder X _____ **Date** _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

1

○ Rx ○ Dental ○ Psych / therapy ○ Ortho
○ Co-payment ○ Over-the-counter ○ Chiro ○ Hospital
○ Office visit ○ Vision ○ Lab ○ X-ray
○ Other: _____

Patient's Name

Service Start Date (MM/DD/YY)

○ Self ○ Qualifying Child
○ Spouse ○ Qualifying Relative
○ Other: _____
Relationship to Account Holder

$ Out-of-Pocket Cost

2

○ Rx ○ Dental ○ Psych / therapy ○ Ortho
○ Co-payment ○ Over-the-counter ○ Chiro ○ Hospital
○ Office visit ○ Vision ○ Lab ○ X-ray
○ Other: _____

Patient's Name

Service Start Date (MM/DD/YY)

○ Self ○ Qualifying Child
○ Spouse ○ Qualifying Relative
○ Other: _____
Relationship to Account Holder

$ Out-of-Pocket Cost

3

○ Rx ○ Dental ○ Psych / therapy ○ Ortho
○ Co-payment ○ Over-the-counter ○ Chiro ○ Hospital
○ Office visit ○ Vision ○ Lab ○ X-ray
○ Other: _____

Patient's Name

Service Start Date (MM/DD/YY)

○ Self ○ Qualifying Child
○ Spouse ○ Qualifying Relative
○ Other: _____
Relationship to Account Holder

$ Out-of-Pocket Cost

4

○ Rx ○ Dental ○ Psych / therapy ○ Ortho
○ Co-payment ○ Over-the-counter ○ Chiro ○ Hospital
○ Office visit ○ Vision ○ Lab ○ X-ray
○ Other: _____

Patient's Name

Service Start Date (MM/DD/YY)

○ Self ○ Qualifying Child
○ Spouse ○ Qualifying Relative
○ Other: _____
Relationship to Account Holder

$ Out-of-Pocket Cost

5

○ Rx ○ Dental ○ Psych / therapy ○ Ortho
○ Co-payment ○ Over-the-counter ○ Chiro ○ Hospital
○ Office visit ○ Vision ○ Lab ○ X-ray
○ Other: _____

Patient's Name

Service Start Date (MM/DD/YY)

○ Self ○ Qualifying Child
○ Spouse ○ Qualifying Relative
○ Other: _____
Relationship to Account Holder

$ Out-of-Pocket Cost

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

$ **TOTAL THIS FORM**

MORE EXPENSES? Complete another form.