Claim Reimbursement Instructions

How to Submit a Claim

We offer three easy ways for you to access your healthcare account funds. **For fastest results, we encourage you to use your healthcare payment card (if applicable) or to submit your claim online.**

Payment card

1. Use your healthcare payment card to directly pay for services at eligible healthcare locations such as doctor's offices, hospitals, and pharmacies.

2. **Save your receipts.** When you swipe the card, a claim is created for you and eliminates the need for you to fill out a claim form. However, documentation may still be required. If a receipt is needed, you will be notified by email or letter within two weeks of your payment card swipe. You can also review if your claim requires receipts online by logging into your online account and visiting the Claim Center.

Online claim submission

1. Go to **tiaa.org** and sign in with your username and password. Under Account Home, click on "Retirement Healthcare Savings Plan Claims Administrator".

2. Follow the onscreen instructions to enter a new claim. Enter the requested information about your claim and continue through the screens to confirm and submit the claim.

Paper claim submission

1. If you didn't use your payment card and are unable to access the internet, complete the Manual Claim Form.

2. Fax it with itemized receipts or other documentation to 1-443-681-4601. When you fax the Manual Claim Form and supporting documentation, there is no need to follow up with a hard copy in the mail. Remember to keep the original claim form and supporting documents for your records.

3. If you choose to mail your claim form and documentation instead of faxing, the address is:

Claims service center
P.O. Box 622337
Orlando, FL 32862-2337

* Please note that new reimbursement claims must be filed each January for that current year

Claim form

Use this form to submit your claims for reimbursement of eligible expenses paid out of pocket that have not already been submitted.

- Do not use this form if expenses were already paid with your healthcare payment card.
- Do not use this form if you already submitted this claim online.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the claims department. (See submission instructions below.)

Personal information	
Name of employer Washington & Lee University	
Employee name (last name, first name)	Social Security Number

Documentation required

You must submit documentation with this form. Documentation must include the patient's name, description of service, date of service and amount charged. Cancelled checks, credit card receipts or balance forward statements are not acceptable. Examples of acceptable documentation include a copy of the Explanation of Benefits (EOB) from your insurance company, an itemized statement from a provider, or an itemized pharmacy receipt (if applicable to your plan).

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Claim Details

Date of service	Patient's name	Relationship to employee	Name of provider	Description of service	Amount requested
	This section should be used for ONE TIME, single reimbursement requests such as dental claims, eye exams, prescription co-pays, etc.				
				Total	$

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Documentation required for recurring claims

You must include a copy of your health plan coverage letter **and** proof of your premium payment. Payment proof can be a cancelled check, credit card receipt, or bank statement.

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Request for recurring claims

Payment date	Member's name	Relationship to employee/retiree	Name of carrier	Plan type	Amount requested
This section should be used for RECURRING		☐ Self ☐ Spouse ☐ Eligible dependent		☐ Medicare Supplement ☐ Medicare Advantage ☐ Prescription Drug Plan ☐ Other health insurance	
claims such as premiums for Medicare Part B,		☐ Self ☐ Spouse ☐ Eligible dependent		☐ Medicare Supplement ☐ Medicare Advantage ☐ Prescription Drug Plan ☐ Other health insurance	
Supplement and Part D RX Plans		☐ Self ☐ Spouse ☐ Eligible dependent		☐ Medicare Supplement ☐ Medicare Advantage ☐ Prescription Drug Plan ☐ Other health insurance	
		☐ Self ☐ Spouse		☐ Medicare Supplement ☐ Medicare Advantage	

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		☐ Eligible dependent		☐ Prescription Drug Plan ☐ Other health insurance	
				Total	

All recurring claims will pay at the same payment frequency. Use separate forms to set different payment schedules.

_____ One time payment _____ Monthly automatic recurring payments
(Documentation does not need to be provided for future months, unless the premium amount changes.)

** Note

_____ If monthly automatic recurring, provide final reimbursement date.
Date will default to the end of the current calendar year. You will need to submit a new claim for the new calendar year if you wish to continue reimbursements after 12/31.

Authorization and certification

Read carefully: This claim will not be processed without your signature.
I certify that these expenses have been incurred by me, my spouse or my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's income tax return.

_____ _____
Signature Date

Submission instructions

For fastest results, fax to: 1-443-681-4601

Or mail to: **Claims service center**
P.O. Box 622337
Orlando, FL 32862-2337

If you have any questions, please contact **Customer service at 1-877-554-1004, option 2.**