AMERICAN BENEFITS GROUP

HOW TO FILE A CLAIM

To be complete, a claim must include a claim form that has been signed and dated by the account holder, and the following five pieces of information:

- Name of the ***recipient*** of the service provided
- Name of the ***service provider***
- ***Date*** of the service provided
- ***Nature*** of the service provided
- ***Cost*** of the service provided

Claims must be accompanied with receipts for the services rendered - **for HRA claims an Explanation of Benefits (EOB) is required** to show that the expense was applied to the insurance deductible.

- Please note that Credit Card receipts or cancelled checks are not valid documentation
- Claims for personal hygiene items and cosmetics are not eligible expenses
- Vitamins and supplements are not eligible without a doctor's prescription
- Massage therapy and weight-loss programs are only allowable to the extent that they are prescribed for a *chronic condition* or *existing disease* and supported by a doctor's note submitted with the claim
- We will keep doctor's note on file but they must be renewed at the beginning of each plan year

Click here for a list of Health FSA qualifying expenses

If you have an HRA, check your Plan Documents for what expenses are eligible under your specific plan.

When you incur a reimbursable expense and are ready to file a claim you can do one of the following:

File a Claim Online through the WealthCare Portal (Registration instructions at the end of this document)

download presentation

- Browse to amben.com/WealthCare
- Login to your account and choose **Add a Claim** under the **Claims** menu
- Enter your claim information, then either:
    - **Attach** your documentation via the portal or
    - **Validate Later**
        - Choose PRINT A CLAIM FORM and fax it with supporting documentation to 877-723-0147
        - Or log in and choose **Claim Activiy** under the **Claims** menu, find your claim and **ADD RECEIPT**

File a Claim Online using the WealthCare Mobile App for smart phones and tablets

- Find out more about our mobile app

Complete a Claim Form manually and send to American Benefits Group

- Download our Claim Form
- Complete and sign the Claim Form, sending it with supporting receipts to American Benefits Group via:

Fax: 877-723-0147

Mail: American Benefits Group, PO Box 1209, Northampton, MA 01061-1209

Securely Email: claims@amben.com - sendsecure.amben.com

The Reimbursements Process

- Claims are paid once a week
- Reimbursements for completed eligible claims received in our office by noon on Fridays, will be processed and checks sent the following Tuesday
- Direct deposits funds*generally will be in participant's bank accounts on Wednesday, however, your bank may take up to three business days to process

***As part of our effort in achieving a 100% paperless office we encourage you to receive your reimbursements directly into your bank account.** If your employer offers the ability to have reimbursements deposited to your bank account, you can set-up direct deposit by logging-in to your account, click **Reimbursement Settings** under the **My Account** tab within the WealthCare Portal. Alternatively, you can complete and sign the Direct Deposit Authorization Form linked here or found under the **Resources** tab, and send (along with a copy of a cancelled check) to American Benefits Group:

- Fax: 877-723-0147
- Email: processing@amben.com

WealthCare Portal Registration Instructions

- Browse to **www.amben.com/WealthCare**
- For First Time Registration
    - In the left column choose **New User? Please click here to register**
    - Follow the instructions and enter all the required information
    - **Username** must be 6-12 characters (alphanumeric)
    - **Password** must be 8-16 characters (follow the provided criteria)
    - **Registration ID** - choose **Employer ID** (Find Employer ID)
    - **Employee ID** is your Soc. Sec. (with no hyphens)

AMERICAN BENEFITS GROUP

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) – CLAIM FORM

Please make copies and save for future claims filing

Name: _____ Last Four Digits of SSN: _____

Employer: _____ Email: _____

Expense Claims *(for you and/or your eligible dependents)*

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred*	Amount Incurred
			TOTAL CLAIMS	$

* Claims can only be submitted for covered individuals.
Please refer to your HRA Plan Document to determine who qualifies as a covered individual.

READ CAREFULLY

In order to have expenses reimbursed out of your Health Reimbursement Arrangement (HRA) you must provide American Benefits Group with the necessary information showing that the expense is consistent with your company's HRA plan design. For plans that are linked to a group health plan you should provide an Explanation of Benefits (EOB) from your health insurance carrier and the bill from your provider, for non-linked plans that cover Section 213(d) expenses please provide a statement showing; the date the service was incurred, the recipient of the service, the nature of the service provided, the name of the service provider, and the cost of the service. These documents should be mailed or faxed along with this form to the address or fax number below (please make sure this form has been signed and completed).

The undersigned participant in the Plan, certifies that all expenses being submitted for reimbursement on this claim form, were incurred during a period when the undersigned was covered under the Company's HRA Plan. In addition the undersigned certifies that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for repayment of all such expenses.

Employee's Signature: _____ Date: _____

Please submit this claim form along with substantiating receipts or statements.

(Receipts must indicate the dates of service, the name of the provider, the nature of the service rendered or product purchased, the person for whom the service was provided and the cost of the service)

Fax Toll Free: 877-723-0147 or email to claims@amben.com

No Fax Machine? Mail to: American Benefits Group •
PO Box 1209, Northampton, MA 01061-1209 • 800-499-3539