FILLING OUT YOUR CLAIM FORM

1. Account Holder Information
   Please print or write legibly when completing the account holder first and last name. Complete a separate form for your spouse and/or covered dependents.

2. Claims for Out-of-Pocket Expenses
   This section should be filled out according to how your Medicare Part B premiums are paid.
   - Check the first box if your Medicare Part B premium is deducted from your Social Security or Annuity check.
   - Check the second box if your Medicare Part B premium is not deducted from your Social Security or Annuity check and is paid by you on an after-tax basis.
   Your service start date is either January 1 of the year for which you are requesting reimbursement, your effective date if after the first of the year, or the first of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.
   Your service end date is either December 31 of the year for which you are requesting reimbursement or the last day of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.
   Fill in the total annual or monthly/quarterly amount of your Medicare Part B payment.

3. Proof of Payment
   Attach proof of Medicare Part B premium payment.

SELECTING YOUR PROOF OF PAYMENT DOCUMENTS
   The Internal Revenue Service (IRS) requires you to provide documents to verify that you paid for a Medicare Part B premium. At a minimum, the document(s) must show:
   - The date you paid your Medicare premium
   - The Medicare Part B account holder’s name
   - The name of your insurance carrier (Blue Cross and Blue Shield Service Benefit Plan)
   - The type of expense (Medicare Part B premium)
   - Proof of premium payment (such as a cleared check, bank statement, or credit card statement that shows the amount you paid for the Medicare Part B premium)

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Submit your completed claim via toll-free fax: (877) 353-9236
OR mail: Claims Administrator, PO Box 14053 Lexington, KY 40512

1 MEMBER INFORMATION

Last Name

First Name

BCBS SERVICE BENEFIT PLAN

Employer Name

Your ID code is a 4-digit combination of your day of birth and the last 2 digits of your SSN. For example, if you were born on the 8th day of the month and the last 2 digits of your SSN are 12, your ID Code would be 0812.

ID Code*

Date of Birth (MM/DD)

Zip Code

2 CLAIMS FOR OUT-OF-POCKET EXPENSES

Check one:

☐ My Medicare premiums are automatically deducted from my Social Security or Annuity check. (Enter annual amount)

☐ I pay my Medicare premiums after-tax. They are not automatically deducted from my Social Security or Annuity check. (Enter monthly/quarterly amount)

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

Out-of-Pocket Cost

3 SUBMIT YOUR PROOF OF PAYMENT

Include proof of payment as an attachment to this form that shows you pay Medicare Part B premiums. Remember to keep the originals of the documents you submit.

If you checked the first box in step 2 above, please submit a copy of your Cost of Living Adjustment (COLA) statement or Annuity Statement.

If you checked the second box in step 2 above, please submit a copy of your Medicare Bill along with your proof of payment (such as a cleared check or bank or credit card statement).

Date ______________________

I certify that the information on this form is accurate and complete. I am requesting reimbursement for Medicare Part B premium expenses I incurred while a member of the Blue Cross and Blue Shield Service Benefit Plan. I have not/will not seek reimbursement of this expense from any other plan or party because I:

1) pay for the premiums through withholding, 2) have paid for the premiums out-of-pocket.

Use of this service indicates my acceptance of the WageWorks User Agreement at fepblue.org/mra (available upon registration; enter username and password or click on First Time User).