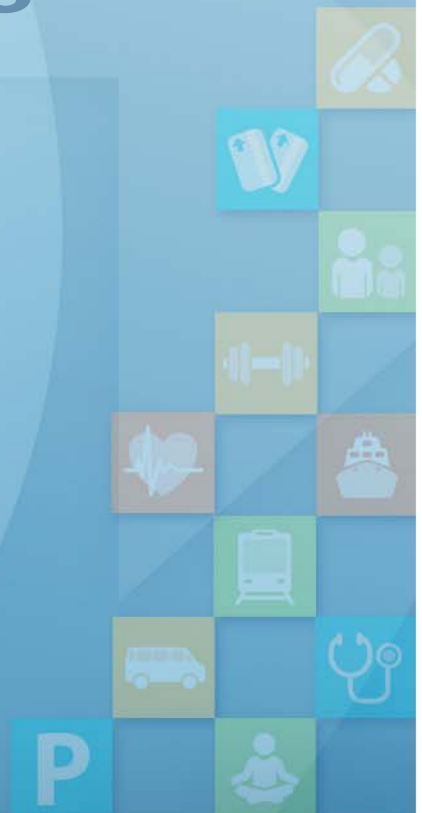


# RRA Insurance Premium Pay Me Back Instructions



## Pay Me Back Claims

**Fill out the Pay Me Back claim form entirely.**

1. Name must match your former employer's records (no middle initial).
2. Fill out section 2 for premium reimbursement. *(Fill out Section 1 only if your Medicare premiums are deducted from your Social Security check)*
  - a. Fill in the first day of the month in which you are claiming through the last day of the month you are claiming.
  - b. The total amount claimed for the entire period.
  - c. Select the participant – “Self” for the retiree, “Spouse”, or “Dependent”
3. Sign the claim form.
4. Fax or mail the claim form and supporting documentation to the phone number/address noted.
  - a. Fax to 877-353-9236 or mail to: Claims Administrator, P.O. Box 14053, Lexington, KY 40512
5. Include documentation showing monthly premium amount from the insurance company (examples of different types of acceptable documentation is listed below)
  - a. Coupon Slips from the insurance company
  - b. Itemized Statement from the insurance company
  - c. Letter from the insurance company

Documentation must include:

  - a. Participant name (name(s) covered individual)
  - b. Healthcare company provider name
  - c. Date(s) of service (coverage period)
  - d. Type of service (type of coverage)
  - e. Premium amount
6. Include proof of payment (any of the examples listed below)
  - a. Bank Statements showing check to “xyz insurance company” is cleared
  - b. Insurance Company Statement showing payment in full for the coverage period
  - c. Ongoing monthly insurance company statements showing previous months premium payment
  - d. A copy of your Social Security “Cost of Living Statement” or Medicare Statement clearly indicating the amount of the monthly Part B, C, or D premium
  - e. Cancelled check for premium payment to insurance company (copy of front & back of cancelled check)
  - f. Credit Card Statements showing payment to insurance company

**TOLL-FREE FAX: (877) 353-9236**

Or, mail to: Claims Administrator, P.O. Box 14053,  
Lexington, KY 40512

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



**ACCOUNT HOLDER INFORMATION**

Last Name

First Name

Retiree SSN (last 4 digits)

Retiree Birth Date (MM/DD)

Employer Name

Spouse/Survivor SSN\* (last 4 digits) (if applicable)

Email Address (complete only if new)

Name Match to  
SRNS/SRR's Record

**CERTIFICATION AND AUTHORIZATION**

Signature of Account Holder X

Date

Signature

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 I have not/will not seek reimbursement of this expense from any other plan or party because I: 1) am required to pay for the premiums through withholding, 2) have paid for the premiums, 3) have already received these products and services. 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.wageworks.com (available upon registration; enter user name and password or click on First Time User).

**CLAIMS FOR OUT-OF-POCKET EXPENSES**

**1. One Time Annual Request for Social Security Administration (SSA) Deducted Premiums**

(Medicare Part B, Medicare Part C – Medicare Advantage, Medicare Part D – Prescriptions)

Relationship to Account Holder

☐ Self

☐ Spouse ☐ Dependent

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

Annual Out-of-Pocket Cost

Patient's Name

**2. Health Plan Premiums Not Deducted from Your Social Security Check**

Relationship to Account Holder

☐ Self

☐ Spouse ☐ Dependent

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

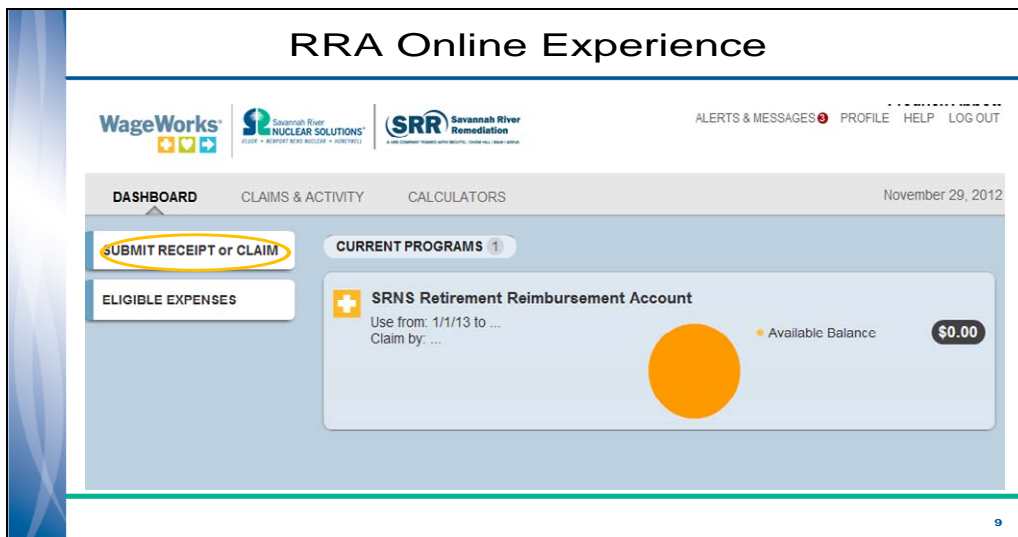
Out-of-Pocket Cost

Patient's Name

Premium  
Reimbursement

Claims can also be submitted online or through your mobile device. Below are steps for requesting an online Pay Me Back reimbursement:

1. Click on "Submit Receipt or Claim"



- Then select "Pay Me Back."

The screenshot shows the 'Submit a Claim' page. The header includes the WageWorks logo, Savannah River Nuclear Solutions logo, and SRR Savannah River Remediation logo. The navigation bar shows 'DASHBOARD', 'CLAIMS & ACTIVITY', and 'CALCULATORS'. The date 'November 29, 2012' is displayed. On the left, there are buttons for 'SUBMIT RECEIPT or CLAIM' and 'ELIGIBLE EXPENSES'. The main content area has two options: 'Health Care Claim Pay Me Back' (highlighted with a yellow circle) and 'Health Care Claim Pay My Provider'. The 'Pay Me Back' option includes the text: 'Request payment to reimburse you for out-of-pocket expenses'. The 'Pay My Provider' option includes the text: 'Request payment to be mailed directly to your provider'. A close button (X) is in the top right corner of the main content area.

- Hit the "Next" Button

The screenshot shows the 'Submit a Claim' page, specifically the 'HEALTH CARE PAY ME BACK CLAIM' section. The header includes the WageWorks logo, Savannah River Nuclear Solutions logo, and SRR Savannah River Remediation logo. The navigation bar shows 'DASHBOARD', 'CLAIMS & ACTIVITY', and 'CALCULATORS'. The date 'November 29, 2012' is displayed. On the left, there are buttons for 'SUBMIT RECEIPT or CLAIM' and 'ELIGIBLE EXPENSES'. The main content area has a 'BACK' button and a 'NEXT' button (highlighted with a yellow circle). Below the buttons, there is a section titled 'Instructions' with a sub-section 'Health Care'. The 'Health Care' section includes the text: 'Submit this claim to get reimbursed for your out-of-pocket expenses for'. Below this, there is a section titled 'Before You Start' with the text: 'Have your receipt in front of you. Enter one receipt at a time.' Below this, there is a section titled 'Follow These Steps' with four numbered steps: 1. Enter Provider Name and Service Dates, 2. Enter Item Details, 3. Review and Submit Claim, and 4. Upload Receipt OR Print Form.

4. Enter or select the Provider Information and Dates of Service, then hit the “Next” button. Repeat the process for each month to ensure correct monthly payment unless annual premium was paid in full.

**Submit a Claim**

WageWorks® Savannah River NUCLEAR SOLUTIONS® SRR Savannah River Remediation

LOG OUT

HEALTH CARE PAY ME BACK CLAIM December 2, 2012

1 2 3 4

BACK Enter Provider and Dates NEXT

Enter the following as displayed on the receipt you will submit to verify this claim.

Provider Name  Maximum 40 characters.

Service Start Date  Day(s) you received care, not day you paid.

Service End Date  Optional. If for more than one day.

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5. Select the Description of Service from the drop down menu. Then select “Other” to produce more options such as “Health Insurance Premium”. Enter the amount and the name of the retiree or dependent and hit the “Next” button.

**Submit a Claim**

WageWorks® Savannah River NUCLEAR SOLUTIONS® SRR Savannah River Remediation

LOG OUT

HEALTH CARE PAY ME BACK CLAIM December 2, 2012

1 2 3 4

BACK Enter Item 1 NEXT

Enter the following as displayed on the receipt you will submit to verify this claim. We will verify and correct all information when we process your claim.

Description  ▼

Amount \$  Your out-of-pocket cost.

Patient Name  ▼ + ADD NEW PATIENT

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6. Confirm the summary and hit the “Next” button.

7. Click “Submit Claim.”
8. Scan and upload the invoice, contract or valid documentation to your computer.
9. Include documentation showing monthly premium amount from the insurance company (examples of different types of acceptable documentation is listed below)
  - Coupon Slips from the insurance company
  - Itemized Statement from the insurance company
  - Letter from the insurance company

Documentation must include:

  - Participant name (name(s) covered individual)
  - Healthcare company provider name
  - Date(s) of service (coverage period)
  - Type of service (type of coverage)
  - Premium amount
10. Include proof of payment (any of the examples listed below)
  - Bank Statements showing check to “xyz insurance company” is cleared
  - Insurance Company Statement showing payment in full for the coverage period
  - Ongoing monthly insurance company statements showing previous months premium payment
  - A copy of your Social Security “Cost of Living Statement” or Medicare Statement clearly indicating the amount of the monthly Part B, C, or D premium
  - Cancelled check for premium payment to insurance company (copy of front & back of cancelled check)
  - Credit Card Statements showing payment to insurance company
11. Follow the instructions to upload your receipt. Participants can also print the documentation and fax to 877-353-9236 or mail to: Claims Administrator, P.O. Box 14053, Lexington, KY 40512.

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