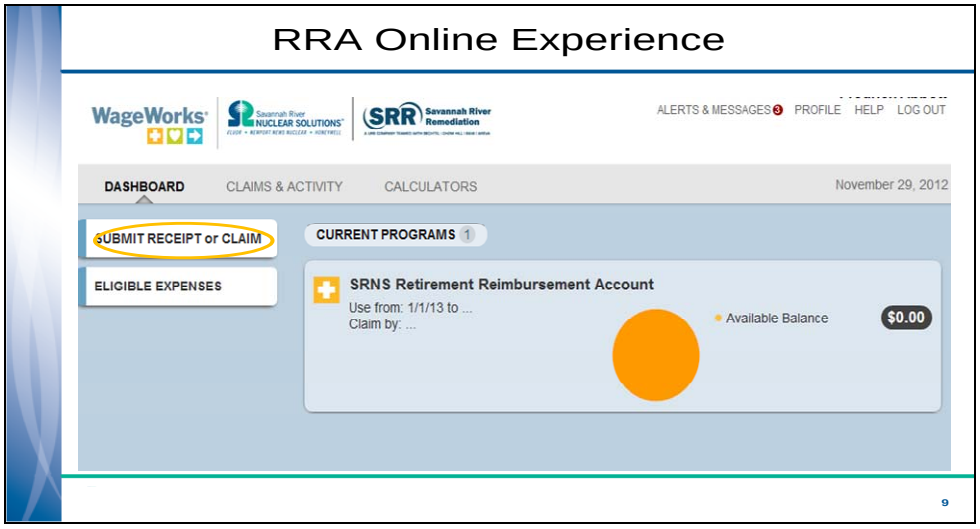
WageWorks®

RRA Insurance Premium Pay My Provider Instructions

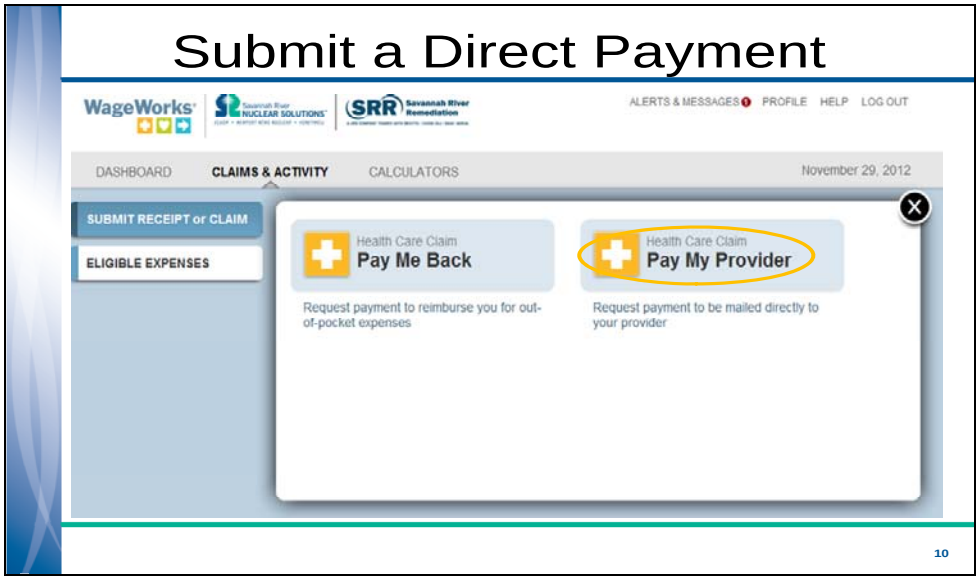
Pay My Provider

Pay My Provider is an option where regular recurring payments are issued directly to the service provider. To implement PMP the participant enrolls online via the WageWorks website.

1. Click on “Submit Receipt or Claim”

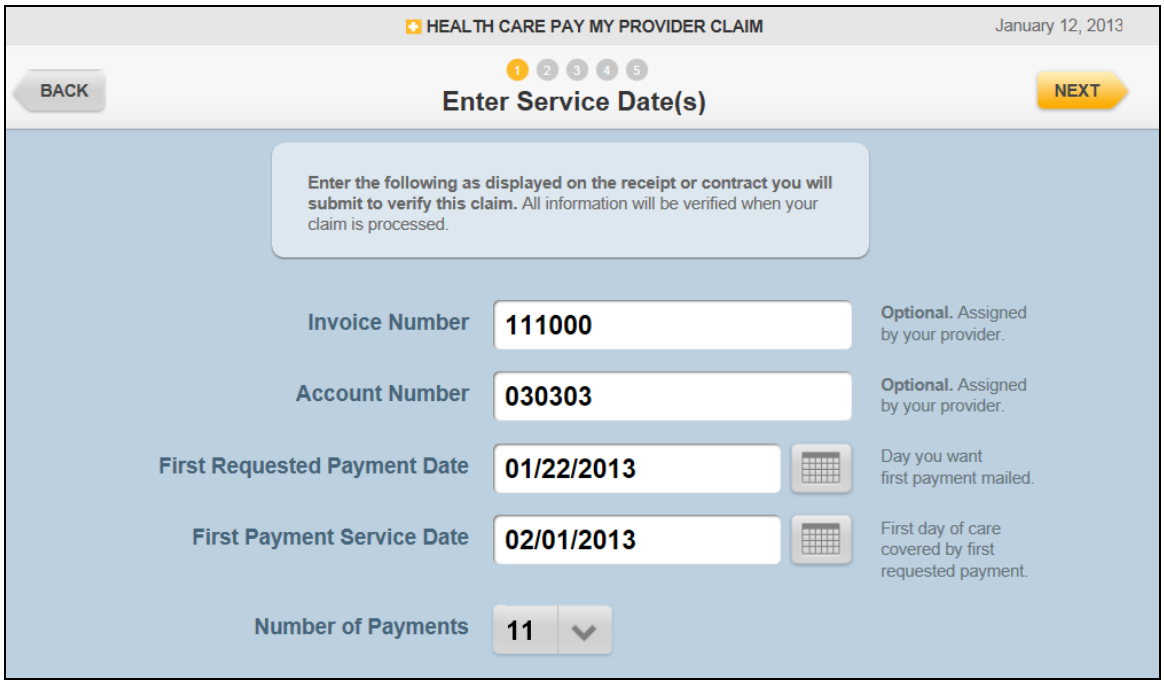


2. Then select “Pay My Provider.”

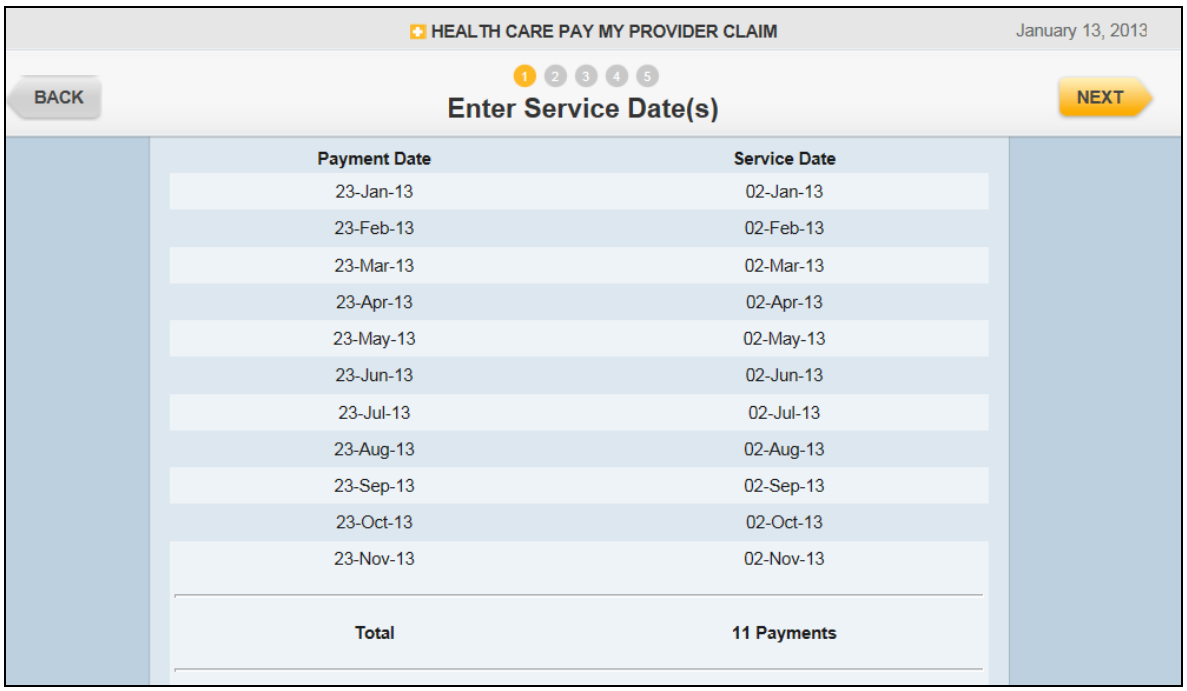


3. Select either a One-Time Payment or recurring Monthly Payment option.

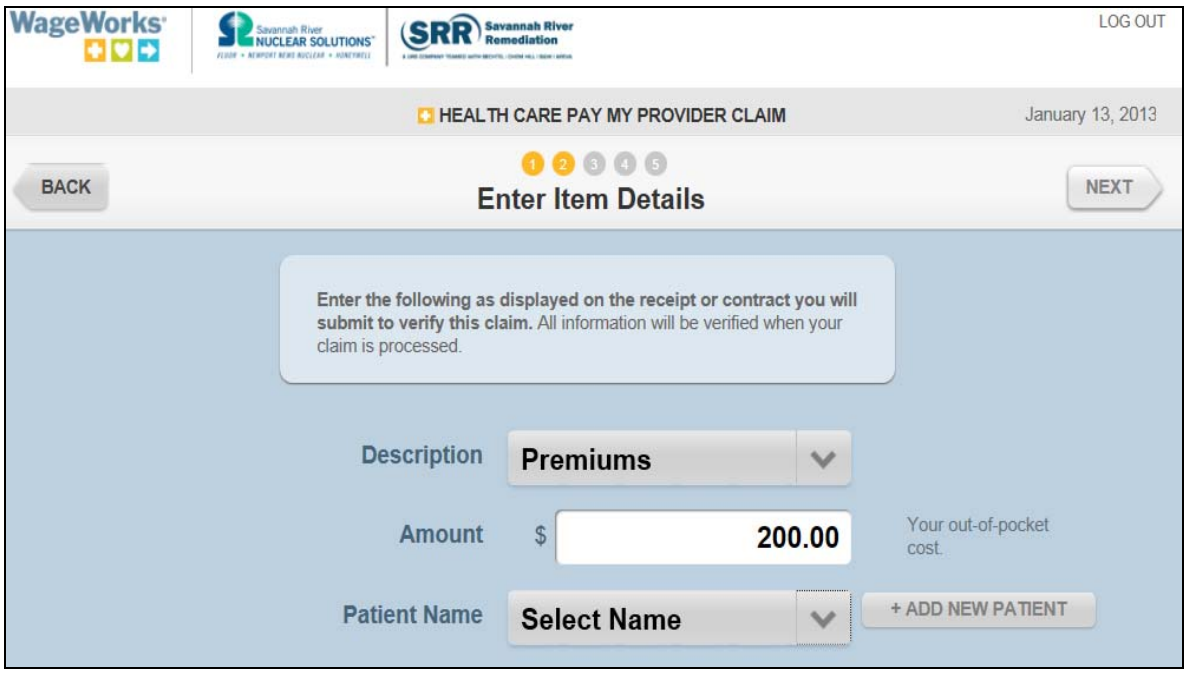
4. Enter invoice/account information if available from your provider. These are optional fields that are sent along with the check to your provider and utilized to further identify your account. Enter the desired date for payment. **At least ten (10) days advance notice is required. Enter the first date of service.** For example, Feb. 1st for February premium. Select the number of payments to be made. Then hit the "Next" button.



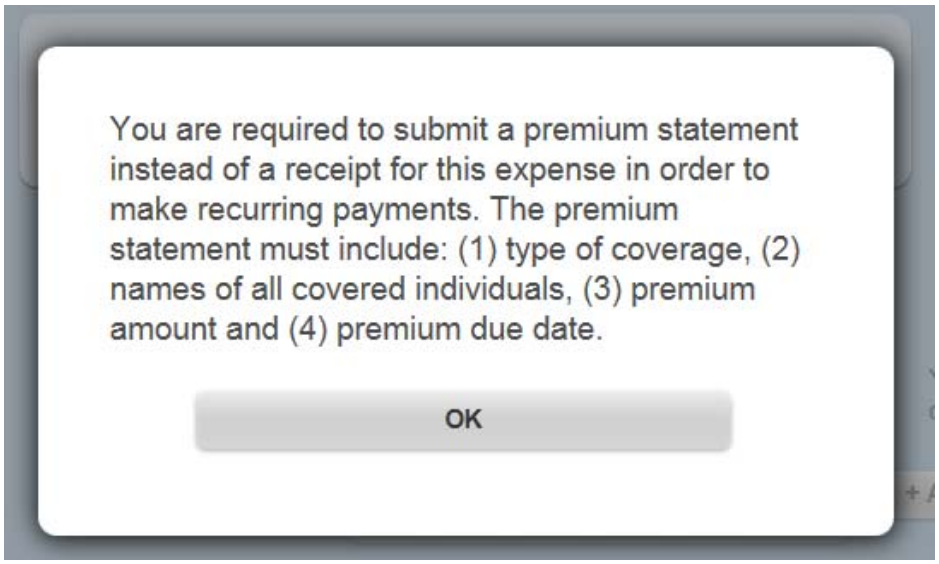
5. Verify the payment schedule and hit the “Next” button.



6. Select “Premium” as the Description of Service from the drop down menu. Enter the amount and the name of the retiree or dependent and hit the “Next” button.

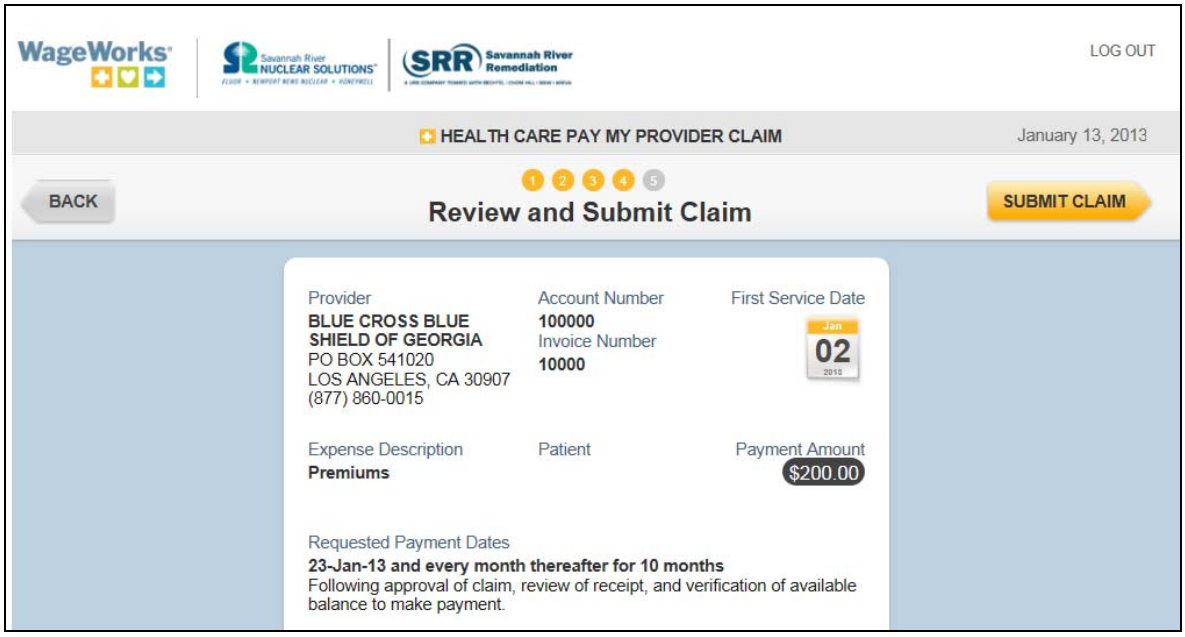


You are reminded to submit a premium statement from your provider. Coupon slips are also acceptable. This supporting documentation is only required once when setting up recurring monthly payments. Select the "OK" button.

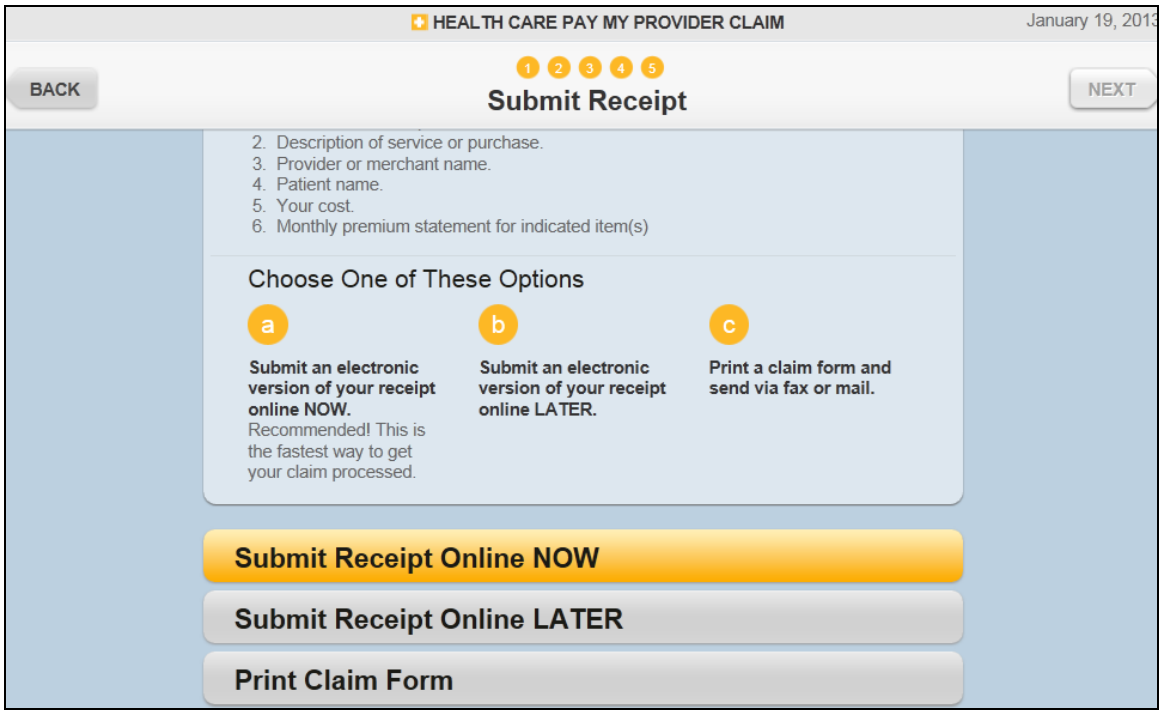


7. Select the Provider from the list or add a new provider name.

8. Confirm the summary and hit the "Submit Claim" button. Payment(s) will be made in the amount requested based on your available balance when this payment is processed. Future payments may be cancelled up to ten (10) business days prior to the requested payment date.



9. Follow the instructions to scan and upload the invoice, contract or valid documentation from your computer.



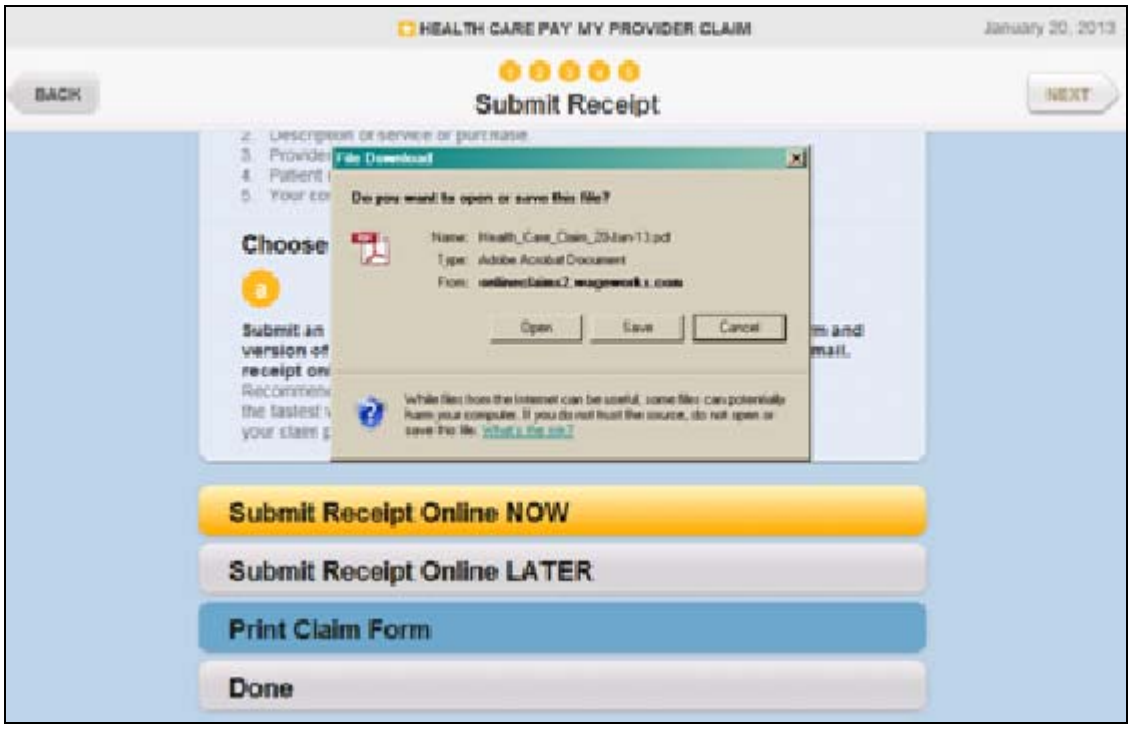
10. Participants can also print the documentation and fax to 877-353-9236 or mail to: Claims Administrator, P.O. Box 14053, Lexington, KY 40512

11. 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

12. Emails will be sent when the payment(s) are made to the participants email address on file with WageWorks. No partial payments are made if there is not enough balance in the account. Any discrepancies are communicated by email notification. Recurring payments will need to be set up each plan year so new documentation will be needed at the beginning of each plan year.

13. To print the information, select “Print Claim Form” and select “Open” to open the file. Select the “printer” icon in the upper left hand part of the screen to print the document.



WageWorks

www.wageworks.com

HEALTH CARE ONLINE PMP CLAIM

Online Pay My Provider Proof of Service

TOLL-FREE FAX: 1-877-353-9236

FAX EACH CLAIM FORM SEPARATELY TO ENSURE QUICK PROCESSING.

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

PMP ID: **OHCPMP1000187827**

Account Holder: Tester Two

Program Sponsor:

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible deductible 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 confirm that by requesting reimbursement here that I 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.wageworks.com (available upon registration; enter user name and password or click on First Time User? link).

INSTRUCTIONS:

1 Fax only ONE FORM and its corresponding appropriate proof of service at a time.

2 Submit this form along with the Provider signature or the appropriate proof of service (such as an itemized bill or explanation of benefits that contains: date of service, description of service, provider name, cost, and name of person receiving care)