HIP Link Account Out-Of-Pocket Expense Reimbursement Claim Form

Note: This form is only for services received from providers that are not enrolled with the Indiana Health Coverage Programs. To search for enrolled providers, visit http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx.

HIP Link may reimburse the employee for amount(s) paid for services received by the individual or eligible family member from a provider who is not enrolled with the Indiana Health Coverage Programs, but is an in-network provider on the employer plan. The reimbursement amount will be the amount for the service received, reduced by the Medicaid allowable cost sharing limits.

Submit the following information for reimbursement:

- Name and RID of member who received the medical service,
- Last four digits of member's SSN,
- HIP Link Employer ID,
- Provider bill or invoice,
- Receipt of payment, and
- Explanation of Benefits (EOB) for the appropriate service and date.

Instructions to Submit the above Information

Step 1: Fill Out the Form

Starting on the far left box please type or print in capital letters, with your letters centered in the middle of the boxes provided as shown below:

A	B	C	D		1	2	3	4

Section 1

- Complete all areas of Member/Employee Information. You will need to provide your **HIP Link RID number** and the last **four digits of your social security number**. **Failure to provide both will result in your request for reimbursement being rejected** and sent back with a letter explaining the reason for your rejection of your request.

Sections 2 & 3

- Do not group expenses; each expense must be listed individually as each expense will be processed separately and will be reflected as separate amounts on your account.
    - Complete all sections of the form including as many lines as needed. Sign and date the agreement at the bottom of the page after reading.
    - Please use section 3 to write expenses. You may attach more than one expense page if you have more expenses than fit on one page. Please attach all completed expense pages with Section 1 and 2 for submission.

Step 2: Attach Supporting Documentation

- In addition to completing each of the fields, you must provide supporting documentation for each payment in the form of:
    - FOR MEDICAL, DENTAL AND VISION REIMBURSMENT:
        - Provider bill or invoice,
        - Itemized receipt for your payment to your medical, dental or vision provider and
        - Explanation of Benefits (EOB) from your insurance company or health care provider.
    - FOR PRESCRIPTION REIMBURSEMENT:
        - Receipt for payment of the prescription
        - Copy of the prescription fill information from the pharmacy attached to the prescription envelope, which includes:
            - Name of the patient for whom the item is prescribed
            - Name of the medication
            - Dosage requirement
            - Provider's address
            - Co-payment information

Step 3: Read the Certification, Sign and Date

- Please read carefully the Certification and then sign your name and write the date to accept the terms and conditions.
- Please **PRINT** legibly in **BLUE** or **BLACK** ink to complete this form. Failure to provide clear, complete, and accurate information will result in a non-paid expense(s). Remember to keep all originals and mail us a copy of the documents you are submitting. **DO NOT** group expenses; each expense **MUST** be listed individually.
- For additional assistance or information, call 1-800-457-4584 or visit www.in.gov/fssa/hip/2489.htm. For those who are hearing impaired, email HIP2.0@fssa.in.gov.

Step 4: Submit Your Form

- **Submit all forms by mail to**:

  HP/HIP Link
  P.O. Box 1995
  Indianapolis, IN 46206-1995

- **Please use more than one Section 3 expense form if needed.**

- **Please DO NOT**
  - Email or fax your reimbursement form
  - Use red ink to complete this form
  - Use highlighter on any receipts or this form
  - Staple copied receipts together or on the form
  - Write outside the boxes
  - Circle applicable items on your receipts

HIP Link Out-Of-Pocket Reimbursement Form

SECTION 1: EMPLOYEE INFORMATION

EMPLOYER HIP Link ID

LAST 4 OF SSN#

EMPLOYEE LAST NAME

EMPLOYEE FIRST NAME

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

IS THIS RELATED TO AN ACCIDENT OR WORK RELATED INCIDENT? YES ☐ NO ☐

SECTION 2: CERTIFICATION

I AGREE THAT:

- I have not already been paid for these expenses from HIP Link and I have not requested and will not receive reimbursement for these expenses from any other source.
- I have submitted the above information honestly and is correct to the best of my knowledge.

I UNDERSTAND THAT:

- Reimbursement is not a guarantee that this payment is tax-free.
- **REIMBURSEMENT IS NOT GUARANTEED EVEN IF YOU FILL OUT THE APPLICATION COMPLETELY AND ACCURATELY.**
- My application will be rejected if I fail to fill out my application completely and honestly.
- The service(s) for which I am requesting reimbursement must be incurred during my period of coverage. I have until 12 months from the date of service to submit my claim for reimbursement of eligible expenses incurred during my period of coverage. If I do not submit my claims within this time limit I will forfeit any funds remaining in my account.
- I cannot use health care expenses reimbursed as a deduction on my personal income tax return.
- The expenses for which I am requesting reimbursement are for myself, my spouse, or an eligible adult dependent(s) through age 26.
- If I give information that is not true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay the state of Indiana for any payments or claims incurred which were paid due to my fraud or error.

I authorize release of payment through my POWER account. I authorize the HIP Link contractor to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers and all other agencies and organizations (including other insurers) to consider the claim for reimbursement.

Member/Employee Signature _____ **Date (MM/DD/YY)**_____

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SECTION 3: HEALTH CARE EXPENSES

CHECK EXPENSE TYPE: ☐**MEDICAL** ☐**DENTAL** ☐**VISION** ☐**PRESCRIPTION**

INDIVIDUAL MEMBER RID THAT RECEIVED SERVICE

INDIVIDUAL MEMBER NAME THAT RECEIVED SERVICE

DATE OF SERVICE: FROM (MM/DD/YY)

DATE OF SERVICE: TO (MM/DD/YY)

AMOUNT REQUESTED (DOLLARS . CENTS)

$.

CHECK EXPENSE TYPE: ☐**MEDICAL** ☐**DENTAL** ☐**VISION** ☐**PRESCRIPTION**

INDIVIDUAL MEMBER RID THAT RECEIVED SERVICE

INDIVIDUAL MEMBER NAME THAT RECEIVED SERVICE

DATE OF SERVICE: FROM (MM/DD/YY)

DATE OF SERVICE: TO (MM/DD/YY)

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