SDCLeagueFunds.org 321 West 44th Street, Suite 804, New York, NY 10036 TEL: 212.869.8129 FAX: 212.302.6195

MEDICAL SPENDING ACCOUNT CLAIM FORM

Reimbursement will be made up to $2,200 per six-month insurance period (Sept-Feb and Mar-Aug), and is subject to terms and conditions of the Plan. Claims may be submitted within one year of your date of service. Benefits are payable only after any payments that are allowable under any other medical insurance which covers you. Please submit an explanation of benefits from your primary insurance carrier with your claim.

If you did not provide evidence that you have other group health plan coverage that meets minimum value standards under the Affordable Care Act during the enrollment period, you will only be eligible for reimbursement of dental and optical "excepted benefits."

Name:	Primary Insurance Carrier:
Member ID#:	Policy Group Number:
Address:	Name of Insured (e.g. self, spouse, etc.):
	Insured's I.D. Number
Telephone:	Email:

Date of Service	Service Provider	Category (Select Code below)	Amount Requested
	Name: Telephone: Address:		
	Name: Telephone: Address:		
	Name: Telephone: Address:		
	Name: Telephone: Address:		
	Name: Telephone: Address:		
		TOTAL:	$

***1) Dental, 2) Deductible/Co-Payment** (i.e., uncovered expenses from another health plan; attach your explanation of benefits from your primary insurance carrier as documentation), **3) Optical, 4) Mental Health** (Services must be performed by a psychiatrist, licensed psychologist, or MSW), **5) Chiropractic, 6) Wellness** (preventive exams, vaccinations, etc.), **7) Other** (Health expenses qualifying as deductible on your personal income tax are allowable, as outlined in IRS publication 502. For a copy call the Fund Office at 212-869-8129.

I hereby authorize the health care provider or my insurance carrier to release any records necessary to verify this claim. I understand that this claim may be subject to audit and may require the submission of additional information.

Signature: _____ Date: _____

Please attach your proof of payment (paid receipt, cancelled check, etc.) along with a copy of the original invoice showing 1) the name and address of the provider, 2) the date of service, 3) the service performed, and 4) the amount charged. Please also include the Explanation of Benefits from your primary insurance carrier for any of the above referenced claims.

Please email the completed claim form and documentation to Health@SDCweb.org.