Medicare Reimbursement Account (MRA) Claim

Instructions for Submitting a Claim

Please read these instructions before completing and submitting your claim.

The Internal Revenue Service (IRS) requires you to provide documents to verify your reimbursement. **The document(s) must also show:**

- the date of coverage or expense
- the name of the person who incurred the expense
- the name of your insurance carrier
- the type of expense (documents must show that you paid for a Medicare Part B premium)
- proof of premium payment

Important:

Complete a separate form for your dependent or spouse.

The form must be signed. If your Power of Attorney signs, please make sure he or she signs the form in the following format *"John Smith, Attorney in Fact for Jane Smith."* Make sure the Power of Attorney is either on file or is submitted with the first claim.

Submit legible copies of your Cost of Living Adjustment (COLA) Statements or other documents providing proof that you pay Medicare Part B premiums with your claim.

You do not need to fax/submit these instructions with your claim.

Section 2–One Time Annual Request for Social Security Administration (SSA) Deducted Premiums (Medicare Part B)

1. Complete this section if your Medicare Part B premium is deducted from your Social Security check.
2. **Service Start Date**–Enter the first of the month in which you are eligible for Medicare Part B for this year.
3. **Annual Out-of-Pocket Cost**–Enter the annual amount of your Medicare Part B payment (This is the monthly amount multiplied by the number of months of coverage.)
4. Include a copy of your Social Security Cost of Living Adjustment (COLA) statement as proof of your expense (typically mailed starting in November the year before it becomes effective) or any other Medicare statement that clearly indicates your annual Medicare B premiums.
5. We will reimburse you based on your annual premiums. Your monthly reimbursement will not be more than the current balance in your account or the maximum benefit available of $1,200.

If your premium is not deducted from your Social Security check, please complete Section 3.

Section 3–Medicare Part B Health Care Premiums ***Not*** Deducted from Your Social Security Check

1. Complete this section if your Medicare Part B premiums are:
   a. not deducted from your Social Security check, ***and***
   b. paid by you on an after-tax basis.
2. Make sure to provide documentation, such as the COLA statement, that shows the premium you pay. After you have paid your Medicare Part B premium, you may use a front and back copy of the cleared check, a bank statement, or credit card statement that shows the Medicare Part B premium payment.
3. The Service Start Date should represent the start date of of coverage you paid for and want to be reimbursed. This date should match the COLA statement.
4. Keep your original receipts and make copies to fax, mail, or email to MVP Health Care.

Please note: Pre-tax deductions for premiums from your payroll or your pension plan are not eligible for reimbursement.

Medicare Reimbursement Account (MRA) Claim

Complete a separate form for your dependent or spouse.

Submit legible copies of your Cost of Living Adjustment (COLA) Statements or other documents providing proof that you pay Medicare Part B premiums with your claim.

Total Amount of this Claim

$ ☐☐☐☐☐.☐☐

Section 1: Account Holder Information

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MVP Member ID No. ☐☐☐☐☐☐☐☐☐☐☐

Date of Birth *(MM/DD/YYYY)* ☐☐ / ☐☐ / 19☐☐

Your Employer Name

Your Email Address

Section 2: One-Time Annual Request for Social Security Administration (SSA) Deducted Premiums

Service Start Date *(MM/DD/YYYY)* ☐☐ / ☐☐ / ☐☐☐☐

Annual Out-of Pocket Cost $ ☐☐☐☐☐.☐☐

Complete Section 3 below *only* if your premium is *not* deducted from your Social Security check.

Section 3: Medicare Part B Health Care Premiums Not Deducted from Your Social Security Check

Service Start Date *(MM/DD/YYYY)* ☐☐ / ☐☐ / ☐☐☐☐

Out-of Pocket Cost $ ☐☐☐☐☐.☐☐

Section 4: Certification and Authorization

I certify that the information on this form is accurate and complete. I am requesting reimbursement for Medicare Part B premium expenses incurred by myself or my dependent(s) while I was a member of the MVP Health Care Standard Option 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; or 2) have paid for the premiums out-of-pocket.

MVP Member Signature

Date

You must include a copy of appropriate proof of premium payment for each amount above.

Submit the completed claim with all supporting documentation to:

Mail: MVP FLEXIBLE BENEFITS DEPT
PO BOX 2207
SCHENECTADY NY 12301-2207

Fax: **315-234-6146**

Email: **myspendingaccounts@mvphealthcare.com**