Medical Reimbursement Account – Online Claims Submission User Guide

Your Medical Reimbursement Account is a great way to save on eligible health care costs, and HealthEquity/WageWorks has worked hard to make the claims and repayment process as easy as possible.

This guide outlines the claims and submission process and the Pay My Provider (PMP) process using the HealthEquityIWageWorks website.

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Before we outline the steps, here are a few things to know about the claims process:

- The Medical Reimbursement Account (MRA) is a health care account with funds that can be used for eligible health care costs. This means that to get your money back, you must first prove the cost is eligible for reimbursement by providing documentation.
- You will need to submit a receipt or other relevant documentation that includes the information below:
 - Provider Name
 - Patient Name
 - Type of Service
 - Service Date(s)
 - Proof of Payment

Online Claims Process

Create Your Account

To start a claim, you will need to first log into your account at **participant.wageworks.com/sfmra.** If you have not already made your account, you will need to do that first.

Filing a Claim

After you have signed up for an account and created your username and password, you can submit claims for eligible health care costs. To submit a claim through the web portal:

1. Log in to your HealthEquity/WageWorks account at participant.wageworks.com/sfmra

| User Name | Malanna as also Madian Daimhannana Alanana (MDA) as haina |
|--|--|
| Password | Welcome to the Medical Kelmbursement Account (MKA) website Welcome to your HealthEquity WageWorks Spending Account Online Services, your confidential, one-stop resource for |
| | information and tools designed to help you better manage your spending accounts. |
| 60 | Your Payment Options |
| Enright your password or user name? | Did you know your reimbursement can be sent directly to your personal bank account? Direct deposit is the quickest and safest way to get reimbursed for your eligible healthcare expenses. Your money is automatically deposited into your account, on time, every time. It's simple to enable direct deposit on your account. <u>Get started now!</u> |
| New Users - Register Here | LETS TAKE A LOOK |
| | Este silio web ne está disponible en español. Si necesita ayuda en español, llame al (866) 697-6078. Es posible que haya un pequeño momento de silencio mientras trasladamos la llamada con un representante que habie español. |
| | 本網站尚無中文版本。 如需中文支援,請致電:(866) 697~6078。 當我們把您的來電轉給中文代表接聽時可能會有短暫的靜默。 |
| | Spending Account Online Services brings you information and tools to: |
| | Review your spending account balances Review claims status |
| | View your statements Download forms |
| | And much, much more |
| | If you don't yet have a user name and password, select the "New User?" button. We recommend that you bookmark this page and visit often. |
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| | |
| | |

2. From the main dashboard, click "Reimburse Me"

| PONSORED ACCOUNTS .cme Corp, Inc. | Medical Full Purpose FSA | Reimburs | ement A | ccount | | MANAGE ACCOUNT |
|---|--|---|--|---|---|---|
| 1edical Reimbursement Account 180.83 | 💰 Reimburse M | Vie 🚅 Pay Pro | wider 📧 Vie | w Claims & Payments | E Pick and Process | General Forms Statements |
| 180.63 a inne 91.61/2023 in 12/31/2023 | Avsitable Bala Avsitable Bala \$180.83 Shop qualified at FSAStored Transa Balances may re RECENT ACTI Date 09/14/2023 08/01/2023 09/01/2023 | ance" UPSA items com up attention UTTY View AI Activity Mail-Order Dial Center for Orth Surgery Mail-Order Dial | Spend It By: 12/31/20 First Day Availa 01/01/202 Claim It By: 03/31/202 and transactions petic Supplies opedic | D23 http: 13 14 Status In Process Not Pail In Process Not Pail In Process Partialh | Station Amount: 52,700.00 Nutritoris Dat 5333.34 Subscription Subscription full - \$1.517.12 - \$12.57 I -\$12.79 PAUL -\$12.79 Paul -\$20.13 | About This Program Eligible Expenses List Eligible Dependents List Manage Cards Authorized Individuals FSAStore.com C |
| | 07/15/2023 | Greenwood Dia | betes Clinic | Completed Paid | -\$233.34 | |

3. Review claims submission instructions and click "Next"

| SF MRA | | | | | | A Home | Messages | O Support | E. | Joe Member 10401340 | Л |
|-------------------------------------|--|--|--|--|---|-------------------------------|------------------------------------|---------------------------------|----------------------|------------------------|---|
| | Dashboard | Claims & Activity | Calculators | Card Center | | | | | | | |
| ВАСК | | | In | structions | | | | | | NEXT | |
| | | Submit thi | s claim to get reim alth Care | Ibursed for you | r out-of-pocket expenses. | | | | | | |
| | | Before Have your Follow Enter Claim | You Start documentation in fr These Steps n Details Revie Docum | ont of you. En w and Upload mentation | ter one item at a time. 3 Submit Claim and Print Form | | | | | | |
| Copyrigh traditional personal | iti: 2002-2022 HealthEquit k of HealthEquity. Inc. No p situation. | y, Inc. All Rights Reserved. All cont art of this site is intended to provi | tents and the design of this do tax or legal advice. Savi | website are copyrigh ags cxamples are provi | ted by HealthEquity. Inc. and way be prof dod for illustrative purposes only. You sh | rected by off ould consult | ter laws, health a professional | Equity is a re advisor rogar | gisterd ding your | | |

- 4. Fill out all the information needed
 - Click "Next No More Items for This Claim"

| SF MRA | MT1 | | | | A Hame | Messages | O Support | E+ Logaut | Joe Member 10401340 |
|--------------------|---|---|---|--|--------------------------------------|-------------------------------------|---------------------------------|----------------------|------------------------|
| | Dashboard Claims & Activity O | Calculators | Card Center | | | | | | |
| ВАСК | | Si Enter | tep 1 of 3 Claim Item 1 | | | | | | |
| | Enter the follow submit to verify the All fields are required | ing as display this claim. unless noted as | red on the documer | ntation you will | | | | | |
| | Provider | Name S | Select Name | ~ | +ADD | NEW PRO | OVIDER | | |
| | Service Star | t Date | | MM/DD/YYYY (ex you received can paid | ample). Da e, not day y | y(s) rou | | | |
| | Service End Date (opt | tional) | | MM/DD/YYYY (ex more than one da | ample). If fo | Dr | | | |
| | Description of Service - Select Fr | om Commo | n Services or Oth | ner Services: | | | | | |
| | Common Se | rvices C | Co-payment (n | nedi 🗸 | | | | | |
| | Other Se | rvices | Select from Ot | hers 🗸 🗸 | | | | | |
| | Ar | mount | \$ | | Your of | ut-of-pock | et cost | | |
| | Patient | Name J | loe Member (A | Acco ∨ | +ADD | NEW PAT | IENT | | |
| | Mileage Reimbursement for This (opt | Claim tional) | Enter Mileage | 9 | | | | | |
| | | C | Enter Locatio | ns | | | | | |
| | | | | | | _ | | | |
| | MORE - Add Anothe | r Item for | This Claim | | | | | | |
| | NEXT - No More Iten | ns for This | s Claim | | | | | | |
| Coj traj per | yrightis 2002-2022 HealthEquity, Inc. All Rights Reserved. All contents enank of HealthEquity, Inc. No part of this site is intended to provide ta- onal situation. | and the design of this cor legal advice. Savin | web site are copyrighted by He gs examples are provided for illu | althEquity. Inc. and may be ustrative purposes only. Yo | protected by oil u should consult | ner laves, health a professional | Equity is a re advisor regar | gisterd ding your | |

- 5. Review and submit or save your claim
 - If a receipt is needed, a pop-up message will appear stating "Saved but Need Receipt"

| SFMRA | | 🕌 Hone M | Conges Super: Legal Dee Member |
|---|---|--|--|
| Dashboa | rd Claims& Activity Calculators Card Co | inter | |
| ВАСК | Step 2 of Review and Sub | 3 mit Claim | SUBMIT CLAIM |
| | Entered Claim Items (1) | Total \$10.00 | |
| | R Delete All Claim Items | | |
| | Dental One Associates (St Co-payment (medical, in-ner for John Doe (Account Holder) | twork) 1 \$19.00 | > |
| | Add Documentation for This Claim | | |
| | "Max file size SMB. Accepted file types are: JPG. PDF. TIFF. GIF, F | NG | _ |
| | The IRS require the following information for valid docum | entation | |
| | Date of service or purchase Description of service or purchase Provider or merchant name Patient name Yaur cost | | |
| | Note: Some plans require additional documentation | | |
| | CERTIFICATION AND AUTHORIZATION I certify that the information on this form is accurate and comp sepresare incurred by myself or an adigited dependent while I is received these products and services and have not and with to detry plan or parky. If an accured under more than one health according to the payment order determined by those plans and | etc. I am requesting reimbursement for eligible as a participant in the plan. I have already teach reimbursement of this sequence from asycense from any care account, reimbursement will be made I as stated on the WageWorks Web Site. | |
| Exceptight/9800-0022 trademarket Heathlight personal situations | Solidificating Jan, A. Filington Encoursed. Al cure nonto and the designed of the costs where are non- ry, Inc. No control this site is interested to provide tax or legal solving. So legal soumples are | y' of that by Haddhoffson's line, and may be protocoad by other provided for HLatrative purposes only. You should consult a prot | is built float yn engelaast ead and ac dorregand gyw, r |

- 6. To submit a receipt, you have three options:
 - Submit Receipt Online NOW (recommended for faster processing)
 - Submit Receipt Online LATER (claim will show "Pending Status" until a receipt is submitted)
 - Download Claim Form (Claim form will be already filled in with the information entered online and can be sent by fax or mail with your receipt for processing)

| SFMRA | A Set Monter Manager Lagur Logar |
|---|---|
| Dashboard | Claims& Activity Calculators Card Center |
| BACK | Step 3 of 3 Attach Documentation |
| | Your Documentation is Needed Your documentation must be received by a plan's "Chain it by' date in order to be considered for payment. All information will be verified when your claim is processed, and corrected if necessary. |
| | Your Documentation Must Include: • Data of scriptor of pruchase • Description of environment • Proving the scriptor of the |
| | Choose One of These Options |
| | Attach Documentation Online NOW |
| | Download Claim Form (PDF) |
| | Done |
| Cocyclythick 2002-2022 File tracements of Health Fig. Bry personal of Mealth Fig. Bry | stands, inc. All Dights Sectores. All to matte and the decision differentiation experipted by Decisional and an experimentation of the international sectores and the international sector |

- 7. To Submit Receipt NOW:
 - Click "Submit Receipt NOW"
 - Click "NEXT" on the instructions screen

| SFMRA | | Hame Messages Support Legalt 10401340 |
|--|--|---|
| Dashboard Claims | & Activity Calculators Card Center | |
| ВАСК | Instructions | NEXT |
| Copyright:0 2002-2022 Health Stank be. All Rig balance for 1 instribution, be part of this is provided all under the | <section-header>Attach Your Documentation Online The state of your dama and payments Follow These States See Payments See Payments</section-header> | protectacily other taxes. Involved and advance regarding your |

- 8. Upload your receipt by clicking the receipt file
 - Review, delete, or add extra claims documentation

| Dr. Test | | \$50.00 |
|-------------|--------------------|-----------|
| DELETE FILE | FILE NAME | FILE SIZE |
| | R_TEST_RECEIPT.PDF | 31.0 KB |

Select the receipt file and click "SUBMIT RECEIPTS"



Medical Reimbursement Account Online Claims Submission – Pay My Provider

HealthEquity/WageWorks offers employees the choice to use their account to pay providers directly for services/ invoices rather than employees paying out of the pocket and then being paid back for the cost. This process is known as Pay My Provider (PMP).

1. To submit an online claim, click "Pay Provider"

| F MRA | SF IVIRA | (| | |
|---------|--|--|---------------------|--------|
| SF MRA | 💰 Reimburse Me | D Pay Provider D View C | laims & Payments | |
| 51.00 / | Available Balance 51.00 Touil Benefit 51.00 | Spend II By Jul 11, 2026 Firt Day Anathate At 10, 2033 Claim By No Claim Deadline | Trail Spent Solo | |
| | Dates Activity | | Statua | Amount |
| | 07/21/2023 Pre-Tax Prog | xam Sponsor Additional Contributio | n Posted | \$1.00 |

- Click on "Payment Selection" on the instructions screen
- 2. Enter Claim Information Make One-Time Payment



3. Fill out the the Service Date and Service End Date (optional) fields, then click "Next"

| + SF MRA PAY | MY PROVIDER CLAIM | | April 18, 2024 |
|---|--|--|----------------|
| Ste Enter Se | ep 1 of 5 rvice Date(s) | | NEXT |
| Enter the following as displayer submit to verify this claim. All in claim is processed. All fields are required unless note | d on the receipt or cont formation will be verified d as optional. | ract you will when your | |
| Service Start Date | 03/01/2024 | MM/DD/YYYY (example). Day(s) you received care. | |
| Service End Date (optional) | | MM/DD/YYYY (example). If for more than one day. | |

4. Enter Claim Information

Fill out these sections:

- Description (Most frequent eligible expenses are listed)
- Amount (Enter out-of-pocket cost)
- Patient Name (Account Holder Name will be listed in drop-down menu to select)
- Add New Patient (optional, lets you add eligible dependent name, if claim is linked to your eligible dependent)
- Invoice Number (optional but recommended)
- Account Number (optional but recommended)

| | + SF MF | RA PAY MY PROVIDER CLAIM | | April 5, 2024 |
|------|---|--|---------------|---|
| BACK | Er | Step 2 of 5 nter Item Details | | NEXT |
| | Enter the following as di submit with this claim. T is processed. All fields are required unle | isplayed on the receipt or contract you Inis information will be verified when your vss noted as optional. | will claim | |
| | Refer to your provider's | invoice for Invoice & Account Number | 5. | |
| | Description | Co-payment (medic | ~ |] |
| | Amount | \$ | 10 | Your out-of-pocket cost. |
| | Patient Name | John Test (Spouse) | ~ | + ADD NEW PATIENT |
| | Invoice Number (optional) | | | Recommended. Provider may require this to process your payment. |
| А | .ccount Number (optional) | | | Recommended. Provider may require this to process your navment |

Click "Next"

5. Enter Claim Information

Fill out these sections:

- Provider Name
- Provider's Mailing Address
- Provider's Daytime Phone Number

| | + SF M | RA PAY MY PROVIDER CLAIM | April 5, 2024 |
|------|--|---|------------------------|
| BACK | Enter | Step 3 of 5 Provider Information | NEXT |
| | Add a New Provider Ensure quick mail deliver provider's involce. All fields are required unit | y by double-checking the address against your | |
| | Name | Dr Mickey Mouse | Maximum 40 characters. |
| | Mailing Address 1 | 1 Main St | Maximum 35 characters |
| | Mailing Address 2 (optional) | | Maximum 35 characters |
| | City | Orlando | Maximum 40 characters. |
| | State | FL 🗸 | |
| | ZIP Code | Ext. (optional) | |
| | Daytime Phone | Area Prefix Line Ext. (| optional) |

Click "Next"

- 6. Review and Submit Claim
 - Review the details and select "Submit Claim"
 - Participants will be requested to submit their receipts

| | + SF MR | A PAY MY PROVIDER C | LAIM | April 5, 2024 |
|------|---|---|--|---------------|
| BACK | Review | Step 4 of 5 and Submit C | laim | SUBMIT CLAIM |
| | Carefully review the inform Your receipt must be receiv considered for payment. All necessary) when your claim | ation before you submit y ed by a plan's "Claim it B information will be verifie n is processed. | your claim: y" date in order to be ed (and corrected, if | |
| | Provider Dr Mickey Mouse 1 Main 81 Orlando, FL 47172 (502) 111-1111 | Account Number Nane Provided Invoice Number Nane Provided | Service Date | |
| | Expense Description Co-payment (medical, in- network) | Patient John Test (Spouse) | Payment Amount | |
| | Requested Payment De As soon as possible Following approval of claim balance to make payment. | ate , review of receipt, and vi | erification of available | |

- If Submit Claim was chosen but a receipt was not attached, a pop-up window will show "Saved but need Receipt!"
- Click "OK" and you will have the choice to submit a receipt on the next step



- 7. Submit Receipt
 - For steps to submit receipt, see page 4

Pay My Provider Claim Instructions: Recurring Payments

- 1. Click on "Payment Selection" on the instructions screen
- 2. Click on "Make Recurring Monthly Payments" to continue
- 3. Enter Claim Information

Fill out these fields:

- First requested payment date
- First payment service date
- Number of payments

| + SF M | RA PAY MY PROVIDER CLAIM | April 18, 202 |
|--|--|---|
| Ent | Step 1 of 5 er Service Date(s) | NEXT |
| Enter the following as a submit to verify this old claim is processed. First requested payment Service Date or late. All fields are required. First Requested Payment Date First Requested Payment Date | All information will be verified when your date must be 10 days in the future or later: date must be 10 days of the First Payment 04/28/2024 03/01/2024 | IDD/YYYY (example). Day you f first payment mailed. IDD/YYYY (example). First of care covered by first ested payment. |
| Number of Payments | Image: Steps Image: Steps Image: Steps | d Upkad aim Receipt(s) |

Select "Next"

4. Review Payment Schedule

| + SF MRA PAY MY | PROVIDER CLAIM | April 18, 2024 |
|---------------------|-------------------------|----------------|
| Step Review Paym | 1 of 5 nent Schedule | NEXT |
| Your Monthly Pay | yment Schedule | |
| Payment Date | Service Date | |
| 28-Apr-24 | 01-Mar-24 | |
| 28-May-24 | 01-Apr-24 | |
| Total | 2 Payments | |

Select "Next"

- 5. Enter Claim Information
 - Fill out the fields below and click "Next" when done

| | + SF MF | RA PAY MY PROVIDER CLAIM | | April 5, 2024 |
|------|--|---|---------------------|---|
| BACK | En | Step 2 of 5 nter Item Details | | NEXT |
| | Enter the following as di submit with this claim. T is processed All fields are required unle Refer to your provider's | Isplayed on the receipt or contract you his information will be verified when your ess noted as optional, invoice for Invoice & Account Number | will claim S. | |
| | Description | Co-payment (medic | > | |
| | Amount | \$ | 10 | Your oul-of-pocket cost. |
| | Patient Name | John Test (Spouse) | ~ | + ADD NEW PATIENT |
| | Invoice Number (optional) | | | Recommended. Provider may require this to process your payment. |
| | Account Number (optional) | |] | Recommended. Provider may require this to process your payment. |

6. Enter Claim Information

Contract Needed as Receipt for Recurring Payments

| Receipt | NE |
|--|--------------------------|
| You are required to submit a contract from your provider instead of a receipt for this expense in order to request recurring payments. | |
| The provider contract must include: | - |
| 1. Provider name | |
| 2. Patient name | |
| 3. Description of service | Your out-of-pocket cost. |
| 4. Payment schedule, including dates of service | |
| 5. Payment amount | + ADD NEW PATIENT |
| ок | |

- 7. Enter Provider Information
 - Fill in the following highlighted sections:

| | ♦ SF MI | RA PAY MY PROVIDER CLAIM | April 5, 2024 |
|------|--|--|------------------------|
| ВАСК | Enter | Step 3 of 5 Provider Information | NEXT |
| | Add a New Provider Ensure quick mail delivery providers invoice. All fields are required unle | v by double-checking the address against you ess noted as optional. | r |
| | Name | Dr Mickey Mouse | Maximum 40 characters. |
| | Mailing Address 1 | 1 Main St | Maximum 35 characters. |
| | Mailing Address 2 (optional) | | Maximum 35 characters. |
| | City | Orlando | Maximum 40 characters. |
| | State | FL 🗸 | |
| | ZIP Code | Ext. (optional) | |
| | Daytime Phone | Area Prefix Line Ext. 502 - 111 - 1111 | (optional) |

- 8. Review and Submit Claim
 - Click "Submit Claim" after reviewing your information

| + SF MR | A PAY MY PROVIDER (| CLAIM | April 5, 2024 |
|---|---|---|---|
| Review | Step 4 of 5 and Submit C | laim | SUBMIT CLAIM |
| Carefully review the inform Your receipt must be receiv considered for payment. All necessary) when your clair | ation before you submit red by a plan's "Claim it I I information will be verifi n is processed. | your claim. By" date in order to be led (and corrected, if | |
| Provider Dr Mickey Mouse 1 Main St Orlando, FL 47172 (502) 111-111 | Account Number None Provided Invoice Number None Provided | Service Date | |
| Expense Description Co-payment (medical, in- network) | Patient John Test (Spouse) | Payment Amount | |
| Requested Payment Da As soon as possible Following approval of claim balance to make payment. | ate , review of receipt, and v | verification of available | |
| | SF MR Carofully review the inform Your receipt must be receive considered for payment.Al necessary) when your clair Provider Dr Mickey Mouse 1 Main St Orlando, FL 47172 (502) 111-111 Expense Description Co-payment (medical, in- network) Requested Payment Da As soon as possible Following approval of claim balance to make payment. | SF MRA PAY MY PROVIDER Of Step 4 of 5 Review and Submit C Carefully review the information before you submit Your receipt must be received by a plants "Claim It considered for payment. All information will be verifi- necessary) when your claim is processed. Provider Dr Mickey Mouse 1 Main St Orlando, FL 47172 (SO2) 111-1111 Expense Description Co-payment (medical, in- network) Requested Payment Date As soon as possible Foliowing approval of claim, review of receipt, and with balance to make payment. Provider State As soon as possible Poliowing approval of claim, review of receipt, and with Description and the payment. | SF MRA PAY MY PROVIDER CLAIM Step 4 of 5 Review and Submit Claim Carofully review the information before you submit your claim. Your receipt must be received by a plans "Claim it By" date in order to be considered for payment. All information wile be verified (and corrected, if necessary) when your claim is processed. Provider Twickey Mouse I Main St Orlando, FL 47172 (S02) 111-1111 Provider Account Number None Provided Invoice Number None Provided Invoice Number None Provided Invoice Number Service Date None Provided Invoice Number Service Date Service Date None Provided Invoice Number Service Date Service Service Date Service Date Service Service Date Service Service Date Service Service Date Service Se |

9. Submit Receipt

• You have three ways to submit a receipt. Pick one:

| + 5 | F MRA PAY MY PROVIDER | CLAIM | April 18, 202 |
|---|--|---|---------------|
| | Step 5 of 5 Submit Receipt | | |
| Your Receipt is New Your receipt must be receiv for payment. All information corrected if necessary. | eded red by a plan's "Claim it By" da will be verified when your cla | ate in order to be considered im is processed, and | |
| Your Receipt Must 1. Date of service or purct 2. Description of service of 3. Provider or merchant no 4. Patient name 5. Your cost | Include: hase ir purchase ame | | |
| Choose One of The | ese Options | | |
| Submit an electronic version of your receipt online NOW. Recommended! This is the fastest way to get your claim processed. | Submit an electronic version of your receipt online LATER. | C Download a claim form to print and send via fax or mail. | |
| Submit Receipt On | line NOW | | |
| Submit Receipt On | line LATER | | |
| Download Claim Fo | orm (PDF) | | |
| | | | |

- After you choose a way to submit, click "Next" to continue
- 10. Upload Receipt



Review, delete, or add extra claims documentation



Confirmation



Press "OK." You have now completed your submission.

Questions?

If you have any questions about submitting a claim online, our HealthEquity/WageWorks Member Services team is available 24/7 to help you with the process or to answer any account questions you have.

Please call us at 1(866) 697-6078.