



<https://participant.wageworks.com/sfmra>

Claim Filing Options:

- **File claim online:** Log in to your account at <https://participant.wageworks.com/sfmra> to submit your claim electronically.
- **File claim via fax or mail:** Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. Fax: **1(866) 599-3058**, US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14857, Lexington, KY, 40512

Instructions to Fill Out This Form:

- Complete ALL account holder information.
- Use your documentation to complete each section of the form, including the following:
 - Provider Name
 - Service Date(s)
 - Patient Name and Relationship to Account Holder
 - Type of Service
 - Patient Responsibility

Tips for Claim Submission

- For a complete list of eligible expenses specific to your plan, log in to your account at <https://participant.wageworks.com/sfmra> and select “Eligible Expense” from the left side of the screen. Only submit claims for eligible expenses.
- An eligible dependent is defined as a spouse, qualifying child, or qualifying relative. A qualifying child is defined as a dependent child up to age 26 or any age if permanently disabled. A qualifying relative is someone who resides with you for more than half of the year. Qualifying children and relatives must not provide more than half of his/her own support.

Tips for Documentation

- Ensure that the documentation is legible.
- Review your plan’s FAQs document to confirm the documentation requirements for claims submission. Failure to submit the required documentation may result in a delay in processing your claim.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- Send only photocopies of your claim form and documentation—keep the originals for your records if submitting via US Mail.
- Cancelled or copies of checks and credit card receipts do not contain all 6 required pieces of information needed to approve your expense and are not acceptable for submission.

Tips for Faxing

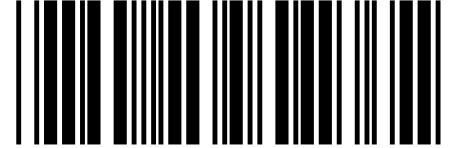
- Do not use a cover page when faxing the claim form and documentation.
- Submit only claims for your own account.

Tips for Viewing Claim Status

- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log in to your account at <https://participant.wageworks.com/sfmra> and select “Profile” in the upper right corner of the screen).



https://participant.wageworks.com/sfmra



- **File claim online:** Join the growing majority of participants who submit their claim online for faster service. Log in to your account at <https://participant.wageworks.com/sfmra> to file your claim electronically and upload your documentation.
- **File claim via fax or mail:** Claim forms may also be filed either via fax or US Mail and sent to the following locations: Fax: 866-599-3058, US Mail: CLAIMS ADMINISTRATOR, P.O. Box 14857, Lexington, KY, 40512
- **Claim processing time:** Claims will be processed within 2 business days after receipt of the form. You may check the status of your claim by logging in to your account at <https://participant.wageworks.com/sfmra>.

ACCOUNT HOLDER:

Last Name grid

First Name grid

ID Code* grid

Account Holder Zip Code grid

* Your ID Code is the last 4 digits of one of the following: Social Security Number or a unique employee number that was given to you by SF City Option.

S F M R A grid

Program Sponsor Name

PROVIDER NAME AND SERVICE DATES	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Provider Name Start and End Dates (MM/DD/YY) <input type="text"/> to <input type="text"/>	Patient Name: _____ Relationship to Account Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Qualifying Child <input type="checkbox"/> Qualifying Relative Type of Service: <input type="checkbox"/> OTC (Over-the-Counter) <input type="checkbox"/> Medical <input type="checkbox"/> Premiums <input type="checkbox"/> Other: _____ <input type="checkbox"/> RX (Prescription) <input type="checkbox"/> Dental/Orthodontia <input type="checkbox"/> Vision	\$ <input type="text"/>
PROVIDER NAME AND SERVICE DATES NAME	PATIENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
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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 healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated on the website. Use of this service indicates my acceptance of the User Agreement at https://participant.wageworks.com/sfmra (click on LOG IN/REGISTER).

CLAIM FORM TOTAL:

\$