

The Judges' Medical Claim Reimbursement Account will reimburse for PERS eligible expenses that the participant or the participant's dependent are responsible to pay out of pocket such as deductibles and copays.

Submitting Claims

- Complete this form and submit via fax or mail along with supporting documentation.
- Each expense needs to be listed as an individual claim on the form. You can file up to 3 claims per form.

Documentation You'll Need to Provide

You must provide proper supporting documentation for your claim to be approved. An Explanation of Benefits (EOB) is the only supporting document required for reimbursement under this account.

An EOB must reflect:

- CalPERS insurance plan or OptumRx (the prescription drug administrator)
- Date of expense
- Name of patient
- Identification of drug or product, or description of service
- Claim amount

***Prescription Information receipts are considered an EOB if it reflects all the necessary information listed above.

SCA001.0718

Note: If you've lost an EOB, contact your health plan provider or pharmacy to request a copy. If you don't provide the correct documentation or complete the claim form correctly, your reimbursement request may be delayed and/or possibly denied.

Getting Reimbursed

Once you've sent your required items, Smart-Choice will process your claim within five business days. If your email address is on file, you'll be notified when documents have been processed. You can review claims status through your benefits website or the mobile app.



Online

- Your Benefits Website mybenefits.ocgov.com
- Smart-Choice Mobile App (available in app stores at no cost)



Fax

1.855.673.6719

Do not include a cover letter and place the claim form before any EOB. Keep the fax confirmation to verify submission.



Mail

Alight Smart-Choice Accounts
P.O. Box 64009
The Woodlands, TX 77387-4009

We are here to help!

If you have any questions regarding submitting your claim, please call: 1-833-476-2347

Smart-Choice Accounts™

Judges PERS Medical Reimbursement Claim Form

ACCOUNT HOLDER

Last Name	First Name
Employer Name	Last 4 of SSN (Optional)
	ZIP Code

JUDGES PERS MEDICAL REIMBURSEMENT CLAIMS

CLAIM 1

	-		-		\$		
Date of Service (MM-DD-YYYY)						Requested Amount	Patient Name
Provider Name							

CLAIM 2

	-		-		\$		
Date of Service (MM-DD-YYYY)						Requested Amount	Patient Name
Provider Name							

CLAIM 3

	-		-		\$		
Date of Service (MM-DD-YYYY)						Requested Amount	Patient Name
Provider Name							

More than three expenses? Print another form (forms can't be reused).

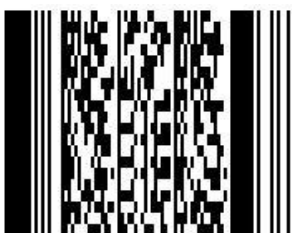
EMPLOYEE CERTIFICATION

By signing below, I certify that the information I'm providing is correct, and that the expenses for which I'm requesting reimbursement (or am validating) were for services or supplies that (1) I (or my eligible dependents) received under the plan, (2) were furnished on or after the date my spending account took effect, (3) haven't been reimbursed through any other source and won't be submitted for future reimbursement, and (4) don't include any amounts that are otherwise payable by plans for which I am (or my dependents are) eligible. For prescription expenses, I am submitting a valid prescription and itemized receipt. I understand that health care reimbursements aren't eligible deductions on my individual tax return. Claim decisions will be made in accordance with the provisions of the plan.

For over-the-counter medicine, I also certify that any expenses for which I'm requesting reimbursement (or am validating) (1) were used primarily for medical care, (2) were used to treat an existing medical condition, (3) were not used for cosmetic purposes, (4) weren't purchased just to benefit general health, (5) were used for my treatment or the treatment of my eligible dependents.

Employee Signature

Date



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Note: Please be sure to include the QR code to the left when mailing or faxing in your claim form. It's vital to ensure claim is routed correctly for processing.