MyChoice® Accounts High Deductible Health Plan (HDHP) Deductible Met Form

How to file your request:

Online: The fastest way to receive reimbursement for your completed claim is through the web or MyChoice® Mobile App. Reimbursement for completed claims submitted via web or mobile app is processed within 2 – 3 business days.

Via email, fax or mail: Fill out your form electronically and submit via email, mail or fax. Completed claims submitted via email, mail or fax may take up to 7 – 10 business days to process.

- **Email**: claims@mychoiceaccounts.com
- **Mail**: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax**: 855-883-8542

This form should be used when:

You are requesting to have your Limited Purpose Healthcare Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) switched to a Full Purpose plan, to submit claims for Medical and/or Pharmacy related expenses after the statutory minimum annual deductible has been met.

To ensure your submission is processed:

You must be enrolled in a High Deductible Health Plan (HDHP) for the plan year in which your request is made.

Submit proper documentation which clearly reflects:

1. **Proof of when** you and/or your family met the required minimum annual deductible
2. Annual deductible was **met with in-network expenses** (out-of-network expenses do not qualify)
3. An explanation of benefits (EOB) from your healthcare provider should provide this information

Wait at least 5 business days before submitting any claims for medical or pharmacy to allow for processing of this request. **If any information is missing or incomplete, it will cause a delay in processing this request.**

SECTION 1: YOUR INFORMATION

◯ SOCIAL SECURITY NUMBER or ◯ EMPLOYEE ID ***(Required, No Dashes)***

COMPANY NAME

EMPLOYEE LAST NAME ***(Required)***

EMPLOYEE HOME ZIP CODE ***(Required)***

EMPLOYEE PREFERRED EMAIL

EMPLOYEE DATE OF BIRTH (MM/DD/YYYY) ***(Required)***

EMPLOYEE DAYTIME TELEPHONE NUMBER ***(Area Code First, No Dashes)***

Provide the annual deductible and the date on which the deductible was met.

Level of Coverage	Annual Deductible	Date Statutory Minimum Was Met (MM/DD/YY)
Single		/ /
Family		/ /

SECTION 2: CERTIFICATION

By submitting this form, I certify and understand that:

Submission of this form and the documentation provided with this request are proof of having met the statutory minimum annual deductible as directed by the IRS.

Once this request is approved and processed, my Limited Purpose Flexible Spending Account or Health Reimbursement Account will pay all Section 213(d) eligible expenses, up to my annual election, for the current plan year.

Any medical and/or pharmacy expenses incurred prior to the date which on I met the statutory minimum annual deductible will not be eligible for reimbursement through my Flexible Spending Account or Health Reimbursement Account plan.

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