HOW TO REQUEST REIMBURSEMENT FROM YOUR HEALTH CARE REIMBURSEMENT ACCOUNT

This form is to be used to request reimbursement for health care expenses only. To view a detailed list of eligible medical expenses, visit **myspendingaccount.adp.com**. All healthcare expenses should first be filed under your employer's healthcare plan or any other coverage you may have. Generally, eligible expenses include: allowable expenses covered but not fully reimbursed by any benefit plans, such as co-payments; and allowable expenses NOT covered by any benefit plans, such as over-the-counter medicines prescribed by an eligible healthcare provider.

Step 1: Fill out the form

- Please print in capital letters, with your letters centered in the boxes provided and fill in all ovals as shown:

A	B	C	D		1	2	3	4

● YES ○ NO

- **For Sections 2 & 5: Complete a separate line for each individual expense. Do not lump expenses together.**
- Complete all sections of the form. Sign and date the bottom of the form.
- If your expenses exceed the number of lines provided, please use page 3.

Step 2: Attach supporting documentation

- Copy your receipts or other supporting documentation onto a white, letter-sized sheet of paper. Place your receipts so they all face the same direction and write your Social Security Number or employee ID at the top of the page.

Step 3: Submit your form (Faxing is faster)

- By Fax: Send the form and copied receipts together as one fax. Do not include a fax cover sheet.
- By Mail: Place the form and the supporting documentation into an envelope, apply the correct postage, and mail.
- If you provide your e-mail address, ADP will e-mail you confirmation we received your form.
- Keep a copy of your completed form and receipts for your records.

Step 4: Receive your reimbursement (Direct Deposit is faster)

- By using Direct Deposit or Electronic Funds Transfer (EFT), you will receive your reimbursement funds up to five days faster than by receiving a check. To sign up, log in to your account at **myspendingaccount.adp.com** and select "Direct Deposit" from the left-side menu.

Type of Supporting Documentation:

- Itemized receipt from your medical, dental or vision provider or pharmacy.
- Claims for OTC medicines must include a pharmacy prescription receipt showing the name of the person for whom the prescription applies, the date of service, amount of the purchase and an Rx number.
- Detailed statement, such as an Explanation of Benefits (EOB) from your insurance company or healthcare provider.
- Documentation must show date of service or purchase, type of service or name of product, amount (your portion of payment).

Please Do NOT:

- Use red ink
- Use a photocopy of the form
- Highlight receipts or any part of the form
- Staple your copied receipts to the form
- Write outside the boxes provided
- If faxing, fax the same form more than once
- Mail the same form that you have faxed
- Include this instruction sheet with your fax
- Submit expenses for multiple plan years on the same form

COVERAGE CODES – You must include a code on Section 2 of the form.

Medical codes

101 = co-payments

102 = over-the-counter medicines

103 = prescriptions or prescription co-pays

104 = general medical

105 = chiropractic/physical therapy

106 = in-patient hospital expense

107 = massage therapy

108 = counseling/psychotherapy

109 = weight/fitness management*

110 = cosmetic surgery & procedures*

111 = vitamins and supplements*

112 = orthotics

113 = electrolysis/hair restoration*

114 = hearing aids

199 = other medical

Dental codes

201 = co-payments

202 = general dental (cleanings, X-rays, crowns, implants, dentures)

203 = orthodontia

204 = teeth whitening, bonding, veneers*

205 = other dental

Vision codes

301 = co-payments

302 = over-the-counter vision (contact solutions, etc.)

303 = general vision (exams, glasses, contact lenses)

304 = non-prescription sunglasses*

305 = vision correction surgery

Other codes

999 = other

*Note: *Indicates items that are generally not eligible healthcare expenses.*

IRS Tax Dependent Definition: The Internal Revenue Code defines a "dependent" as a qualifying child who must reside with you for more than half the year and must not provide over half of his/her own support; this includes full-time students ages 19 through 24. A "qualifying relative" is an eligible individual if (1) you provide more than half of the individual's support and (2) the individual is not a qualifying child of you or any other taxpayer. Based on recent changes made by the health care reform legislation (Patient Protection and Affordable Care Act (PPACA)), tax-free reimbursement of medical expenses incurred by adult children who have not reached age 26 by the end of the taxable year may be permitted. Please note that any questions regarding the status of an individual as either a qualifying child, a qualifying relative, or an adult child must be discussed with a qualified tax advisor in conjunction with the provisions of your employer's plan.

Questions? Need a list of eligible expenses? Visit myspendingaccount.adp.com or call ADP Customer Service at 1-800-807-8847 (option 1).

REIMBURSEMENT FORM – OBP HEALTHCARE EXPENSES

Use only CAPITAL LETTERS, completely fill in ovals, and don't use red ink.

FAX TO: 1-866-643-2219 TOLL FREE

For additional expenses, please use next page.

XHXCXRX

Reset Form

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

COMPANY NAME: COUNTY OF ORANGE

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

FOR ADP ONLY

EMPLOYEE EMAIL

DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR HEALTHCARE EXPENSES

EXPENSE 1

COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY) FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS) $.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 2

COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY) FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS) $.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 3

COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY) FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS) $.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

SECTION 3: CERTIFICATION

Please read Certification Statement thoroughly before signing.

I hereby certify that:

- I have read and understand the instructions on page one.
- The information contained within this form is correct.
- I have not received reimbursement previously for these expenses from my Healthcare Account or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with the IRS Definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free.
- Healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Healthcare Account. I hereby authorize ADP or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider claim for reimbursement under my Healthcare Account.

FAX: 1-866-643-2219 Toll Free

MAIL: ADP Spending Accounts
PO Box 34700
Louisville, KY 40232

PHONE: 1-800-807-8847 (option 1)

Employee Signature _____ Date _____

XHXCXRX

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

Reset Form

USE THIS PAGE FOR ADDITIONAL HEALTHCARE EXPENSES.

BHBABDB

Reset Form

SECTION 4: YOUR INFORMATION (ABBREVIATED)

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

EMPLOYEE LAST NAME

EMPLOYEE HOME ZIP CODE

SECTION 5: YOUR ADDITIONAL HEALTHCARE EXPENSES

EXPENSE 4
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 5
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 6
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 7
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO

EXPENSE 8
COVERAGE CODE (SEE PAGE 1)

Please Select Code

DATES OF SERVICE (MMDDYY)
FROM

TO

REQUESTED AMOUNT (DOLLARS . CENTS)
$.

PATIENT DATE OF BIRTH (MMDDYY)

COVERED BY INSURANCE? YES NO

EOB ATTACHED? YES NO