# Alternative Health Benefits Reimbursement Request

## For Skidmore College Employees

### Instructions for Completing and Submitting a Request

Use this form to request reimbursement of services or activities based on your plan's specific well-being benefit. Members can receive up to $300 per plan, per contract, per calendar year. Request forms must be received no later than one year after purchase. Include all required documentation, as requests cannot otherwise be processed and will be returned to you. If completing this form electronically, you may need to save or download a copy to your digital device to engage the electronic signature function. If you submit your Reimbursement Request by mail, retain a copy of the form and your receipts for your records.

**Print and mail this completed form and your receipts to:**
ASO CLAIMS-SKIDMORE COLLEGE
MVP HEALTH CARE
PO BOX 1434
SCHENECTADY NY 12301-1434

**Or email to:** lmanzer@mvphealthcare.com

You will be sharing Personal Health Information when you email this form. You may be required to download and save a copy of the form in order to add an electronic signature.

**Or download and email this completed form and your receipts to:**
**skidmorealternativewellness@mvphealthcare.com**

### Section 1: Member Information *(Please print)*

| **Member** Name *(Last, First, Middle Initial)* | Subscriber ID No. *(See your MVP Member ID card)* | Group No. **00490027** |
|---|---|---|
| Date of Birth *(MM/DD/YYYY)* | Phone No. ( ) | Email |
| Street Address | City | State / Zip Code |

### Section 2: Reimbursement Request(s) *(Please print)*

**Include all receipts with this request** as proof of your expense. See page 2 to learn more about what qualifies for reimbursement.

| **Service Provider Name and Phone No.** **Service Provider Address** | **Date of Service** | **Description of Service** | **Date Paid** / / **20** **Amount Paid** (No sales tax) |
|---|---|---|---|
| | | | / / 20 |
| | | | $ |
| | | | / / 20 |
| | | | $ |
| | | | / / 20 |
| | | | $ |
| | | | / / 20 |
| | | | $ |
| | | **Total** | $ 0.00 |

### Section 3: Certification and Authorization

I authorize the release of information about my well-being benefit utilization to my health plan. I certify that the information provided in support of this submission is complete and accurate and that I have not previously submitted for, or been reimbursed for, these same services.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.**

**I have read and agree to this authorization.**

*Subscriber's Signature* *Date*

## How to Submit Your Reimbursement Request

1. This form may be used for well-being reimbursement requests only. The maximum $300 credit is provided to each subscriber (contract holder). For example, a family of four on one plan contract would be eligible for one maximum reimbursement, per calendar year.
2. Reimbursement applies to the calendar year in which the service is provided. For example, if a service was paid for in December, but it was provided in January of the current calendar year, it will apply to the current calendar year's reimbursement.
3. All reimbursement forms must be received no later than one year after the date you paid for the service.
4. You must pay for the service before submitting a request for reimbursement. For each reimbursement you are requesting, you must attach:

   **A copy of** an itemized bill, statement, debit/credit card statement, or receipt that is preprinted, stamped, or on company letterhead and includes the service provider's name and address (balance forward/prior balance statements are not acceptable).

   **The documentation from the service provider** that must include all of the following information:

   - The name of the service provider
   - The type of service provided
   - Your out-of-pocket cost for the service, including date(s) of all payment(s)
   - The name of the person(s) receiving the service

   If the above information is not on the printed receipt, write it on the receipt prior to submission. **Please note that sales tax is not reimbursable.**
5. Please allow 4–6 weeks for reimbursement. Reimbursement may be refused if the service provider does not meet MVP's benefit and quality standards.
6. Follow the instructions for completing and submitting a request at the top of the form. **Be sure to sign the form and keep a copy of the form** and your receipts for your record.
7. If you have questions about completing this form or your plan's specific benefit, contact the MVP Customer Care Center at the phone number on the back of your MVP Member ID card.

## Examples of Services That Qualify for Reimbursement

A valid receipt is required for a purchase to be eligible for reimbursement.

- Acupuncture
- Child birth classes
- Fitness center membership
- Fitness classes
- Fitness equipment
- Fitness training sessions with a training coach
- Homeopathic
- Hypnotherapy (weight control and smoking cessation)
- Massage therapy
- Nutritional counseling
- Registration fees for walking and running events
- Weight control programs
- Yoga classes

## Examples of Services That Do Not Qualify for Reimbursement

- Clothing
- Fees/expenses associated with motorized sports (snowmobiling, jet skiing, four wheeling)
- Services provided by non-licensed massage therapist
- Purchase made via private sale or social media

## Questions about what qualifies for reimbursement or your plan's specific benefit?

Call the MVP Customer Care Center at the number on the back of your MVP Member ID card.