Alternative Health Benefits Reimbursement Request

For Skidmore College Employees

Instructions for Completing the Request Form

Employer Responsibilities

This form may be used for alternative health benefits reimbursement requests only. The maximum $300 credit is provided to each subscriber (contract holder); for example, a family of four would be eligible for one reimbursement per plan, per calendar year.

Reimbursement applies to the calendar year in which the service is paid. For example, if a service was provided in December, but you paid for it in January of the current calendar year, it will apply to the current calendar year's reimbursement.

All reimbursement request forms must be received no later than one year after the date you paid for the service.

You must pay for the service before submitting a request for reimbursement. For each reimbursement you are requesting, you must include 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 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)

If the above information is not on the printed receipt, please write it on the receipt prior to submission. Sales tax is not reimbursable.

Please allow 4–6 weeks for reimbursement. Reimbursement requests that are not submitted according to the aforementioned guidelines will be returned for you to correct and resubmit. Reimbursement may be refused if the service provider does not meet the MVP benefit and quality standards.

Sign the form and return it with the required documentation to MVP Health Care®:

Mail: ASO Claims–Skidmore College, MVP Health Care, PO Box 1434, Schenectady NY 12301-1434

Email: **psmith@mvphealthcare.com**

Because you are sharing Personal Health Information when you email this form. Be sure to confirm that you are sending it and other required documentation to the correct email address, noted above.

Examples of Goods and Services that Qualify for Reimbursement

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

Examples of Goods and Services that Do Not Qualify for Reimbursement

- Attire, athletic footwear, or fees/expenses associated with motorized sports, such as snowmobiling, jet skiing, or four wheeling
- Food and dietary supplements, other than those purchased directly from a healthy weight support program
- Physical activities at country clubs, such as golf, swimming, or skiing, that are not billed or itemized separately from membership fees and/or dues, or strictly social memberships at country clubs

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

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

Alternative Health Benefits Reimbursement Request

For Skidmore College Employees

Instructions for Completing this Request

Use this form to request reimbursement of services or activities based on your plan's specific well-being benefits. Members can receive up to $300 per plan, per calendar year. Requests must be received no later than one year after the date you paid for the service or activity. Include all required documentation; requests cannot be processed otherwise, 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. **Please print.**

Submit this completed Reimbursement Request to:

Mail: ASO Claims–Skidmore College, MVP Health Care, PO Box 1434, Schenectady NY 12301-1434

Email: **psmith@mvphealthcare.com**

Section 1: Member Information

*(*Required Information)*

MVP Subscriber ID No.*

Employer Group No.* **490027**

Member Name*

Date of Birth*

Phone No.*

Street Address*

City*

State*

Zip Code*

Section 2: Reimbursement Request(s)

*(*Required Information)*

Please include all receipts with this request as proof of your expense. See page 1 to learn more about what qualifies for reimbursement.

Service Provider Name and Phone No. / Service Provider Address		Description of Service	Service Date / Payment Date	Amount Paid
				$
				$
				$
				$
		Total Number of Receipts Attached:		**Total Paid: $**

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 or activities.

*Subscriber's Signature**

Date

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 be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

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