



CITY OF REDDING ALTERNATIVE THERAPY (MASSAGE) CLAIM FORM

This form is to be used for massage services NOT covered under the Blue Shield PPO medical coverage.

1. Instructions (incomplete claim forms will not be processed)

– Please see the full list of instructions on the following page.

2. Employee Information

New Address? Check the box if the address listed below is new

Employee Name Blue Shield Identification #

Street Address City / State / Zip Code

3. Expenses for Alternative Therapy (Massage)

Name of Employee/ Dependant	Name of Provider	Date of Service	Description of Expenses	Amount Requested
> Enter the total amount requested for reimbursement and attach receipts before sending				

4. Employee Authorization

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under the Alternative Therapy benefit and understand that request follows the rules as outlined in the SPO and under Physical Therapy Alternatives Rules noted on the next page.

Employee Signature Date

5. Employee Release if Emailing Claims

According to the regulations as set forth by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have established the appropriate administrative, technical, and physical safeguards to prevent Protected Health Information (PHI) from intentionally or unintentionally being used or disclosed in violation of HIPAA's requirements. The safeguards EBS has put in place include sending your supporting receipts, EOBs and claim forms through our secure fax or through US mail.

If you choose to send us your documentation containing PHI through email (custserv@ebsbenefits.com), you understand that such email is not secured and you are responsible for securing your information in an appropriate manner. Any transmission of your PHI through email may result in unauthorized disclosure of your PHI and, consequently, an exposure risk to you or your dependents. By sending us your claims via email and by signing the below, you understand that EBS is not responsible for any information transmitted by you or your agent on your behalf.

Employee Signature Date

CITY OF REDDING ALTERNATIVE THERAPY (MASSAGE) CLAIM ~ INSTRUCTIONS

Instructions: (*incomplete claim forms will not be processed*):

- Complete the Employee Information requested under Section 2.
- Fully complete all fields in Section 3 and attach an itemized bill from the Provider.
- Read the Employee Authorization and sign under Section 4 (you must also sign under Section 5 if you choose to email your claims).
- Keep complete copies of everything submitted to EBS for your records (you will be charged a fee for EBS to send you the copies of the submitted information).
- Completed claim forms should be faxed or mailed to the following address:
EBS, P.O. Box 11657, Pleasanton, CA 94588
Fax: 925.460.3929 (preferred)
You may also email your claims to claims@ebsbenefits.com

NOTES: to ensure the timely processing of your claim please fill out the claim form completely. Please print clearly (or type) all requested information on the claim form. Be sure to select the "new address" box if there has been an address change. Be sure your calculations of the amount to be reimbursed are correct, and that they match the receipts or the Explanation of Benefits (EOB) from the insurance company. Attach receipts for all eligible expenses.

CITY OF REDDING ALTERNATIVE THERAPY (MASSAGE) PLAN IMPORTANT INFORMATION

Receipts submitted for reimbursement MUST include the following information:

- name of the patient (you, your spouse or dependent);
- the date the service was provided;
- the name of the service provider;
- the amount/cost of the item or service provided

Physical Therapy Alternatives Rules (per SPD)

- The Plan is subject to a \$650 per year limit on reimbursement for this program.
- A doctor's prescription is required for participation in this program and must be certified by a Physician at least annually.
- Such alternative to Physical therapy, such as Treatment by a Certified Massage Therapist (CMT), is in lieu of the more traditional Physical therapy and will not be in addition to such therapeutic activities.

TOP REASONS THAT CLAIMS ARE DENIED:

- Expenses submitted were incurred outside of the Plan Year.
- Expenses were previously submitted and paid.
- The information provided on the claim form (particularly your name, address) is not clearly legible. Claim forms that cannot be read are filed away until they are identified.

NOTE: If your claim cannot be processed, you will be notified in writing, explaining the reason and requesting the necessary information needed to process your claim.

EBS CUSTOMER SERVICE: If you need Customer Service assistance, please contact EBS via phone from Monday through Friday, 8 am to 5pm, Pacific Standard Time at 888 327-2770; or you can send an e-mail at customerservice@ebsbenefits.com





DIRECT DEPOSIT FORM AUTHORIZATION AGREEMENT

Mail completed forms to Employee Benefit Specialists, Inc., PO Box 11657, Pleasanton, CA 94588 or fax to: 925.460.3929

This form can be used to initiate, change or cancel your direct deposit. This service alleviates the time spent waiting for a check in the mail and is available to all plan participants. Please note – this form must be sent to EBS two weeks before the reimbursement method is changed.

All requests for Direct Deposit must be submitted on this form and include a voided check for the account. Forms without a voided check attached will not be processed. Deposit slips are not acceptable as appropriate routing numbers may not be available.

Reimbursement will only occur if you have submitted a claim to EBS with receipts for eligible expenses. EBS does not guarantee payments into your account on any date. EBS is not responsible for bank charges of any type that you may incur for direct deposit transactions. Do NOT assume that a payment has been made to your account at any time. You are solely responsible for checking with your bank as to the deposit amount and date of direct deposits made to your account. You may use the on-line account balance system (through EBS' website), EBS' automated account balance system by phone or contact EBS Customer Service to check the status of your flexible spending account.

By submitting this form, you understand that your claims reimbursements will be deposited into the listed account.

Please place an x in the appropriate box:

- Initiate Direct Deposit
- Change Account
- Cancel Direct Deposit

Employer Name: _____

Employee Name: _____ SSN: _____

Employee Address: _____ Daytime Phone: _____

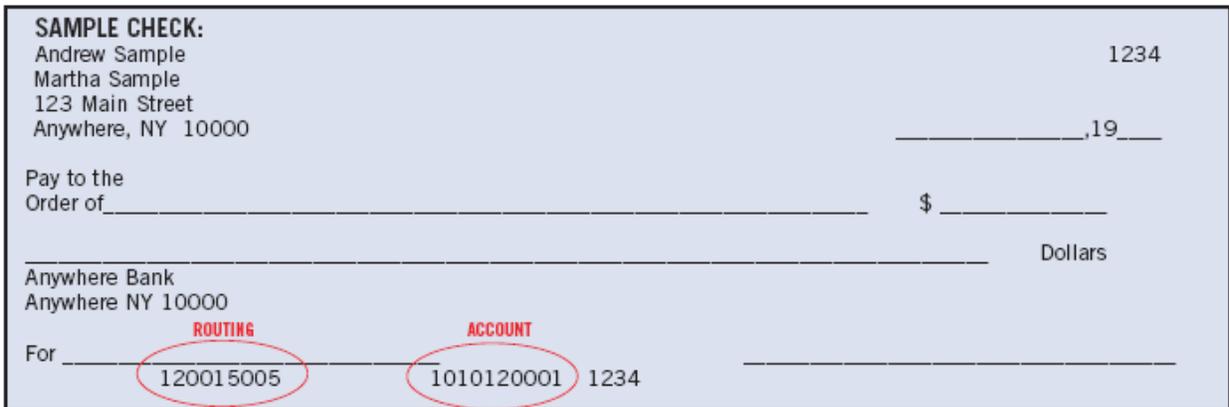
Bank Name & Address: _____

Bank Routing #: _____ Bank Account #: _____

- Checking Account
- Savings Account

Authorizing Signature: _____

For assistance in finding routing and account numbers please see below:



Routing Number must be nine digits. If the first two digits are not 01 through 12 or 21 through 32, your direct deposit request will be rejected. The Account Number can be up to 17 characters (both numbers and letters) - include hyphens but omit spaces and special symbols.

