Important Health Spending Account (HSA) claiming information

What expenses can I claim?

- Health Spending Accounts are governed by taxation rules and regulations developed by Canada Revenue Agency (CRA).
- A Health Spending Account (HSA) may be used to claim health or dental related costs incurred by you and/or your eligible dependents.
- Any eligible medically-related expense that could be used to meet requirements for inclusion on a plan participant's personal income tax return (in accordance with the Income Tax Act-Medical Expense Tax Credit) is eligible for reimbursement.

For Group Health/Dental Plan Expenses
(for example, prescription drugs, dental, physiotherapy and vision claims)

If a medical expense qualifies as an eligible claim through a group health/dental plan, then it is eligible under your HSA. The majority of medical expenses that qualify for an HSA fall under this category.

Examples include co-pay amounts, deductibles, vision care expenses and orthodontic procedures.

Alberta Blue Cross will validate, assess and adjudicate these claims.

A general listing of eligible expenses can be found on the Alberta Blue Cross web site at www.ab.bluecross.ca/gpmd_hsa.html.

Other Medical Expenses
(for example travel expenses, vehicle modifications and home renovations)

Other medical expense may qualify for your HSA plan.

Since Canada Revenue Agency (CRA) decides what expenses are eligible under an HSA, and since the eligibility of claims is based on personal taxation and health status, Alberta Blue Cross is not in a position to confirm whether your claims of this nature are allowable under CRA rules and guidelines.

The CRA has published a list of general expenses that are eligible. This list can be found at www.cra-arc.gc.ca/tax/individuals/topics/income-tax/return/completing/deductions/lines300-350/330/allowable-e.html

Alberta Blue Cross will reject claims for expenses that are non-health related.

If your claim is unique in nature and you are unsure whether it is eligible, we advise you to contact Canada Revenue Agency at 1-800-959-8281 to obtain an official ruling.

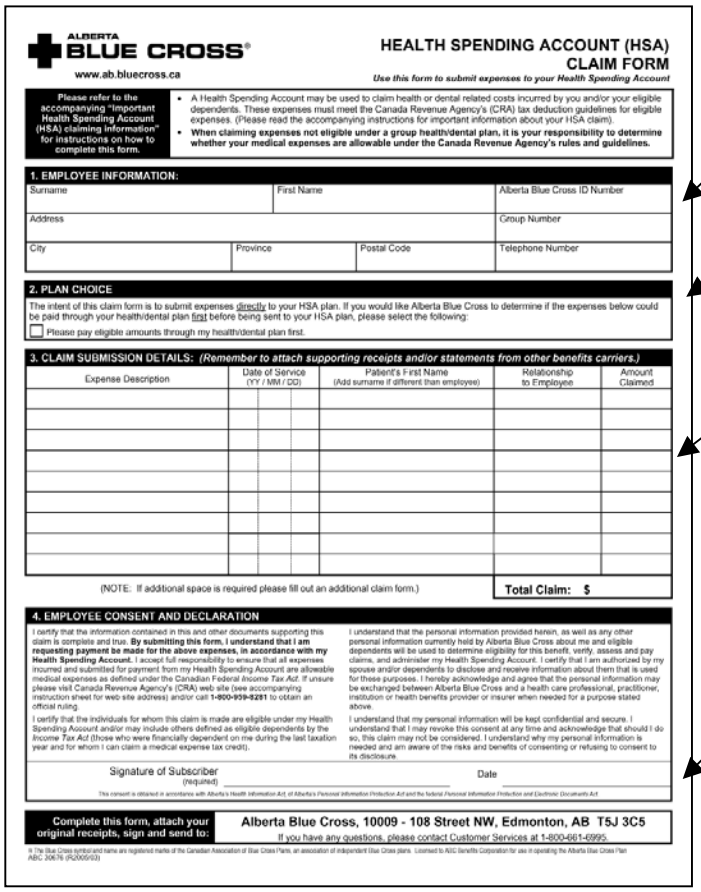
Who is eligible to claim under my HSA plan?

Your immediate dependents eligible under your employer plan, plus those dependents who meet Canada Revenue Agency's (CRA) broader definition of eligible dependents for tax deduction purposes.

Original Receipts

Attach original receipts for each expense claimed and keep copies for your records. If you have claimed these expenses under another plan, the original Explanation of Benefits from that plan and copies of receipts must be attached to this claim.

Sample of a Health Spending Account (HSA) claim form.



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www.ab.bluecross.ca

HEALTH SPENDING ACCOUNT (HSA) CLAIM FORM
Use this form to submit expenses to your Health Spending Account

Please refer to the accompanying "Important Health Spending Account (HSA) claiming information" for instructions on how to complete this form.

- A Health Spending Account may be used to claim health or dental related costs incurred by you and/or your eligible dependents. These expenses must meet the Canada Revenue Agency's (CRA) tax deduction guidelines for eligible expenses. (Please read the accompanying instructions for important information about your HSA claim).
- **When claiming expenses not eligible under a group health/dental plan, it is your responsibility to determine whether your medical expenses are allowable under the Canada Revenue Agency's rules and guidelines.**

1. EMPLOYEE INFORMATION:

Surname	First Name	Alberta Blue Cross ID Number
Address		Group Number
City	Province / Postal Code	Telephone Number

2. PLAN CHOICE

The intent of this claim form is to submit expenses directly to your HSA plan. If you would like Alberta Blue Cross to determine if the expenses below could be paid through your health/dental plan first before being sent to your HSA plan, please select the following:

☐ Please pay eligible amounts through my health/dental plan first.

3. CLAIM SUBMISSION DETAILS: *(Remember to attach supporting receipts and/or statements from other benefits carriers.)*

Expense Description	Date of Service (YY / MM / DD)	Patient's First Name (Add surname if different than employee)	Relationship to Employee	Amount Claimed

(NOTE: If additional space is required please fill out an additional claim form.) **Total Claim: $**

4. EMPLOYEE CONSENT AND DECLARATION

I certify that the information contained in this and other documents supporting this claim is complete and true. **By submitting this form, I understand that I am requesting payment be made for the above expenses, in accordance with my Health Spending Account.** I accept full responsibility to ensure that all expenses incurred and submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Federal *Income Tax Act*. If unsure please visit Canada Revenue Agency's (CRA) web site (see accompanying instruction sheet for web site address) and/or call **1-800-959-8281** to obtain an official ruling.

I certify that the individuals for whom this claim is made are eligible under my Health Spending Account and/or may include others defined as eligible dependents by the *Income Tax Act* (those who were financially dependent on me during the last taxation year and for whom I can claim a medical expense tax credit).

I understand that the personal information provided herein, as well as any other personal information currently held by Alberta Blue Cross about me and eligible dependents will be used to determine eligibility for this benefit, verify, assess and pay claims, and administer my Health Spending Account. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I hereby acknowledge and agree that the personal information may be exchanged between Alberta Blue Cross and a health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

Signature of Subscriber (required) _____ Date _____

This consent is obtained in accordance with Alberta's Health Information Act, of Alberta's Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act.

Complete this form, attach your original receipts, sign and send to: Alberta Blue Cross, 10009 - 108 Street NW, Edmonton, AB T5J 3C5
If you have any questions, please contact Customer Services at 1-800-661-6995.

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ABC 30676 (R2005/03)

1. Employee Information

Please complete this section in full to ensure that your claims are processed promptly and accurately.
Refer to your Alberta Blue Cross identification card for your ID number and group number.

2. Plan Choice

The intent of this claim form is to submit expenses directly to your HSA plan.

However, if you choose the selection box, Alberta Blue Cross will determine if the expenses could be paid through your health/dental plan first before being sent to your HSA plan. This would ensure that your health/dental plan is fully optimized before using HSA credits.

3. Claim Submission Details

Patient's First Name
Please provide the patient's first name. If the patient's surname is different than the employee's, please provide this along with the first name.

Expense Description
Please list each expense separately with its date of service and amount to be claimed through your HSA.

4. Employee Consent and Declaration

Signature of Subscriber
Signing this claim form acknowledges your responsibility to ensure that all expenses incurred and submitted are allowable medical expenses as defined under the Canadian Federal *Income Tax Act*. Signing also gives us your consent to use personal information to determine eligibility for this benefit, validate, assess, adjudicate and administer your HSA. You also acknowledge that as part of the claiming process you have been authorized by your spouse and eligible dependents to disclose and receive information about their claims. Please make sure that they are aware of and agree to this process before you begin submitting their expenses for reimbursement.

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HEALTH SPENDING ACCOUNT (HSA) CLAIM FORM

Use this form to submit expenses to your Health Spending Account

Please refer to the accompanying "Important Health Spending Account (HSA) claiming information" for instructions on how to complete this form.

- A Health Spending Account may be used to claim health or dental related costs incurred by you and/or your eligible dependents. These expenses must meet the Canada Revenue Agency's (CRA) tax deduction guidelines for eligible expenses. (Please read the accompanying instructions for important information about your HSA claim).
- **When claiming expenses not eligible under a group health/dental plan, it is your responsibility to determine whether your medical expenses are allowable under the Canada Revenue Agency's rules and guidelines.**

1. EMPLOYEE INFORMATION:

Surname	First Name		Alberta Blue Cross ID Number
Address			Group Number
City	Province	Postal Code	Telephone Number

2. PLAN CHOICE

The intent of this claim form is to submit expenses directly to your HSA plan. If you would like Alberta Blue Cross to determine if the expenses below could be paid through your health/dental plan first before being sent to your HSA plan, please select the following:

☐ Please pay eligible amounts through my health/dental plan first.

3. CLAIM SUBMISSION DETAILS: *(Remember to attach supporting receipts and/or statements from other benefits carriers.)*

Expense Description	Date of Service (YY / MM / DD)	Patient's First Name (Add surname if different than employee)	Relationship to Employee	Amount Claimed

(NOTE: If additional space is required please fill out an additional claim form.)

Total Claim: $ $0.00

4. EMPLOYEE CONSENT AND DECLARATION

I certify that the information contained in this and other documents supporting this claim is complete and true. **By submitting this form, I understand that I am requesting payment be made for the above expenses, in accordance with my Health Spending Account.** I accept full responsibility to ensure that all expenses incurred and submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Federal *Income Tax Act*. If unsure please visit Canada Revenue Agency's (CRA) web site (see accompanying instruction sheet for web site address) and/or call **1-800-959-8281** to obtain an official ruling.

I certify that the individuals for whom this claim is made are eligible under my Health Spending Account and/or may include others defined as eligible dependents by the *Income Tax Act* (those who were financially dependent on me during the last taxation year and for whom I can claim a medical expense tax credit).

I understand that the personal information provided herein, as well as any other personal information currently held by Alberta Blue Cross about me and eligible dependents will be used to determine eligibility for this benefit, verify, assess and pay claims, and administer my Health Spending Account. I certify that I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I hereby acknowledge and agree that the personal information may be exchanged between Alberta Blue Cross and a health care professional, practitioner, institution or health benefits provider or insurer when needed for a purpose stated above.

I understand that the personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered. I understand why the personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. I have read and understood this Employee Consent and Declaration.

Signature of Subscriber (required) _____ Date _____

This consent is obtained in accordance with Alberta's *Health Information Act*, Alberta's *Personal Information Protection Act* and the federal *Personal Information Protection and Electronic Documents Act.*

Complete this form, attach your original receipts, sign and send to:

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