BlueCross BlueShield
Federal Employee Program

# Medicare Reimbursement Account (MRA) Claim Instructions

How to submit claims by fax or mail

## IMPORTANT

- **2026 claims must be filed by April 30, 2027**
- **2025 claims must be filed by December 31, 2026**

## STEPS TO FILLING OUT YOUR CLAIM FORM

### Before you start

Have your relevant documentation handy. This may include your current plan details, Cost of Living Adjustment Statement, Annuity Statement, Medicare Bill and bank or credit card statements. Don't include this instruction page with your faxed or mailed claim. If you need more information on Medicare Reimbursement Account, visit fepblue.org/mra-info.

### Step 1:

Fill in your member information in section 1 of the form.

*Note, you will need to complete a separate form for you, your spouse and any covered dependents also claiming Medicare Reimbursement.*

### Step 2:

Fill in section 2 by checking one of the two options for how your Medical premiums are paid.

- **Check the first box** if your Medicare Part B premium is deducted from your Social Security check and enter the total Medicare payments in the out-of-pocket cost boxes.
- **Check the second box** if your Medicare Part B premium is not deducted and is paid by you on an after-tax basis and enter the monthly or quarterly amount in the out-of-pocket cost boxes.

Everyone must enter their service start and end date:

- Your service start date is either January 1 of the year for which you are requesting reimbursement, the date you qualified (if after the first of the year), or the first of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.
- Your service end date is either December 31 of the year for which you are requesting reimbursement or the last day of the month(s) if you pay out-of-pocket on a monthly/quarterly basis.

### Step 3:

Attach proof of payment documents. The Internal Revenue Service (IRS) requires you to provide documents to verify that you paid for a Medicare Part B premium. At a minimum, the document(s) must show:

- ✓ The date you paid your Medicare premium
- ✓ The Medicare Part B account holder's name
- ✓ The name of your insurance carrier (Blue Cross and Blue Shield Service Benefit Plan)
- ✓ The type of expense (Medicare Part B premium)
- ✓ Proof of premium payment (such as cleared check, bank statement, or credit card statement that shows the amount you paid for the Medicare Part B premium)

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HealthEquity

# MEDICARE REIMBURSEMENT ACCOUNT (MRA)
## PAY ME BACK CLAIM FORM

- Print or write legibly.
- Do not use a fax cover sheet.

**Submit your completed claim via toll-free fax:** (877) 353-9236
**OR mail:** Claims Administrator, PO Box 14053 Lexington, KY 40512

## 1 MEMBER INFORMATION

Last Name

First Name

BCBS SERVICE BENEFIT PLAN
Employer Name

ID Code*

Your ID code is a 4-digit combination of your day of birth and the last 2 digits of your SSN. For example, if you were born on the 8th day of the month and the last 2 digits of your SSN are 12, your ID Code would be 0812.

Date of Birth (MM/DD)

Zip Code

## 2 CLAIMS FOR OUT-OF-POCKET EXPENSES

**Check one:**

☐ My Medicare premiums are automatically deducted from my Social Security or Annuity check. (Enter annual amount)

☐ I pay my Medicare premiums after-tax. They are not automatically deducted from my Social Security or Annuity check. (Enter monthly/quarterly amount)

Service Start Date (MM/DD/YY)

Service End Date (MM/DD/YY)

$ Out-of-Pocket Cost

## 3 SUBMIT YOUR PROOF OF PAYMENT

**Include proof of payment as an attachment to this form that shows you pay Medicare Part B premiums. Remember to keep the originals of the documents you submit.**

**If you checked the first box in step 2 above, please submit a copy of your Cost of Living Adjustment (COLA) statement or Annuity Statement.**

**If you checked the second box in step 2 above, please submit a copy of your Medicare Bill along with your proof of payment (such as a cleared check or bank or credit card statement).**

Date _____

I certify that the information on this form is accurate and complete. I am requesting reimbursement for Medicare Part B premium expenses I incurred while a member of the Blue Cross and Blue Shield Service Benefit Plan. I have not/will not seek reimbursement of this expense from any other plan or party because I:
1) pay for the premiums through withholding, 2) have paid for the premiums out-of-pocket.

Use of this service indicates my acceptance of the User Agreement at fepblue.org/mra (available upon registration; enter username and password or click on First Time User).