CareFirst

ADOPTION ASSISTANCE REIMBURSEMENT CLAIM FORM

Please check all that apply.

☐ This form includes documentation for a previously denied claim

☐ This form includes a new email address

☐ This form includes a new address

Number of pages _____

Section A – Account Holder Information (Please Print)

ACCOUNT HOLDER'S NAME LAST	FIRST	MIDDLE	SPENDING ACCOUNT ID# SA
STREET ADDRESS			SOCIAL SECURITY # (if SA# not known)
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
ACCOUNT HOLDER EMAIL ADDRESS		EMPLOYER NAME	

Section B – Claim Detail (Please Print)

All fields in this section must be completed. If information is missing, the processing of your claim may be delayed or denied. Supporting documentation must be attached. See the reverse side of this form for more detailed Claim Filing directions.

Date(s) of Service	Name of Eligible Child	Date of Birth	Social Security Number (if known)	Name of Service Provider	Type of Service Provided	Reimbursement Requested
						$
						$
						$
						$
						$
						$
					TOTAL	$

Section C – Account Holder Signature

I certify that I have received and read a copy of the CareFirst Adoption Assistance Program Description and that the expenses for which I am seeking reimbursement are qualified adoption expenses under the Program. I understand that CareFirst does not make any commitment or guarantee that amounts paid to me under this Program will be excludable for my income for federal, state or local tax purposes, or that any favorable federal, state, or local tax treatment will apply to or be available to me. I understand that it is my obligation to determine the federal, state, and local tax consequences of any payment made under the Program. I acknowledge that to the extent any income tax exclusion or credit may be available to me, I cannot claim both the exclusion and the credit for the same expense. I also understand that I may be asked to provide further details about some expenses.

ACCOUNT HOLDER SIGNATURE	DATE

Questions? Call 866-758-6119.

Send via secure email only:
carefirstdocuments@hellofurther.com

Fax to:
866-231-0214

Mail to:
Further c/o CareFirst P.O. Box 64193
St. Paul, MN 55164-0193

How to File a Claim

To receive reimbursement for adoption expenses that are not covered by any other plan follow the steps below.

1. **Provide supporting documentation** of your eligible expenses for each claim line item. This documentation is required by the IRS and can be an Explanation of Benefits (EOB), detailed receipt or provider statement. **Cancelled checks do not qualify as IRS acceptable documentation.**

   Supporting documentation must include:

   - Date of service or purchase
   - Name of Eligible Child
   - Name of provider of service
   - Type of service provided
   - Amount charged for each service

2. Fax or mail your claim form with supporting documentation to Further c/o CareFirst.

   - To **fax** your claim form and supporting documentation:
     a) Complete and sign the claim form using a dark pen.
     b) Make sure your supporting documentation is on white paper.
     c) Fax to: 1-866-231-0214
   - To **mail** your claim form and supporting documentation:
     a) Complete and sign the claim form using a dark pen.
     b) Include copies of documentation. Do not mail originals.
     c) Mail to: Further c/o CareFirst, P.O. Box 64193, St. Paul, MN 55164-0193

Note: Do not highlight items on your claim form or supporting documentation, as it interferes with claims processing. Instead, circle with a dark pen as needed.

3. Keep a copy of the claim form and supporting documentation for your records or upload to our document storage found at www.carefirst.com/myaccount.
4. To receive your reimbursement faster, sign up for direct deposit by logging into your account at www.carefirst.com/myaccount.

Appeal Information

The Explanation of Processing Report explains how your claim was processed based upon the information submitted to us. You or your designated representative may appeal a denial, partial denial, or reduction of your claim by following our appeal procedures. You may contact customer service at 866-758-6119 for an explanation of your appeal rights. If you disagree with our decision on your claim, you have the right to submit a written request for an appeal review to Further c/o CareFirst, P.O. Box 64193, St. Paul, MN 55164-0193. We can send you a form to file your appeal or you can obtain a copy of the appeal form at www.carefirst.com/myaccount. You have until the later of your plan's run-out end date or 180 days from the date of this notice to file an appeal. If you have terminated employment during the year or if you are unsure of your plan's run-out end date, please contact your group representative or contact our customer service department. You may also submit any documents, records, or other information that relates to your claim for benefits. Upon receipt of your request, we will provide a full and fair review of your appeal and a written notice of our decision either by letter or an explanation on the Explanation of Processing Report within 30 days.