GRCC
GRAND RAPIDS COMMUNITY COLLEGE

Submit Claim Flex Administrators
via one of the following methods
Email: claims@flexadministrators.com
Fax: (616) 454-6090
Mail: Flex Administrators
3980 Chicago Drive-Suite 230
Grandville, MI 49418

VISION REIMBURSEMENT CLAIM FORM

PATIENT NAME*ONE NAME PER CLAIM FORM*	RELATIONSHIP TO EMPLOYEE	SEX	BIRTHDATE	TODAYS DATE

EMPLOYEE NAME (LAST, FIRST, MIDDLE)	Last 4 of Social Security Number	Employee Group

ADDRESS	CITY STATE ZIP

*COMPLETE THIS SECTION IF PATIENT IS COVERED BY ANOTHER PLAN	Subscriber Name	Last 4 of Social Security Number	Name and Address of Employer
	Plan Name	Last 4 of Social Security Number	Name and Address of Carrier

***If you are covered by another plan, please submit documentation from other plan that eligible charges were processed (e.g., an EOB).**

DATE OF SERVICE	DESCRIPTION OF SERVICE	$AMOUNT

DOCTOR NAME OR SERVICE PROVIDER	TELELPHONE

SUBTOTAL	
LESS AMOUNT PAID BY OTHER INSURANCES	
LESS DISCOUNTS	
TOTAL	

I HEREBY CERTIFY:

1. That the above is a true report of expenses paid by myself, not having been reimbursed from another source
2. That the patient indicated is either myself, my spouse, or my eligible dependent children.
3. That I grant permission to contact my doctor for clarification of the billing statement attached.

NOTE: Be advised that any person knowingly and with intent to injure, defraud or deceive Grand Rapids Community College in filing incomplete or misleading information may be guilty of a criminal act punishable under law. Grand Rapids Community College reserves the right to determine its own level penalty up to and including discharge.

EMPLOYEE SIGNATURE:	

ATTACH ITEMIZED BILL AND PROOF OF PAYMENT

Form Revised 10/2020

GUIDELINES FOR DENTAL/VISION PLAN REIMBURSEMENT

A separate claim form needs to be submitted for each patient.

An **itemized statement of services rendered**, from the provider, is **required** for each claim submission.

Claim forms must be completely filled out, do not write "See Attached" on the claim form—doing so may cause our claim to be denied.

Ensure that you **inform GRCC Human Resources of any address changes**. Any discrepancy in addresses may delay the processing of your claim.

Do not to send in copies of personal checks and/or credit card statements as proof of payment/receipt; an actual receipt from the provider needs to be submitted.

Expenses must be considered eligible for reimbursement per the Dental and Vision Reimbursement Plan Document. **The current reimbursement of warranties/insurance for eyeglasses is not permissible.** A list of reimbursable expenses can be found in the Plan Document that is available on the GRCC Employee Benefits webpage at: https://www.grcc.edu/humanresources/employeebenefits/dentalandvisionreimbursementbenefitplan

Coverage for Oral Surgery-Wisdom Teeth Extraction is covered under the WMHIP Community Blue Health Plans, please review instructions on how to submit your reimbursement request to BC/BS. Instruction are posted on the HR/Benefits Website under Dental and Vision Reimbursement Plan. Flex Administrators will require an EOB for this type of service.

Since our plan is a "secondary plan", GRCC requires Flex Administrators to determine if there is other primary insurance available, and requires **a copy of the primary carrier's Explanation of Benefits (EOB),** when applicable. **I**f an employee indicated on the Enrollment Form that a spouse or dependents have other insurance, an "EOB" will be required from the primary carrier, and should accompany your initial claim submission. Without an "EOB", Flex Administrators will pend the claim and request additional information regarding possible other insurance.

Orthodontics: Reimbursement for orthodontics is only available on the initial payment for services, and then for each additional monthly payment on the balance. The plan will **not** reimburse a participant a one lump-sum payment at the end of the treatment period. When submitting a reimbursement request for orthodontic services, please provide Flex Administrators with the orthodontic contract, which details the total cost, the initial down payment, the monthly payment schedule, and the date on which the contract will be paid in full.

Any bills that are not "paid in full" will not be reimbursed, until they are paid in full. Any bills for services that are not being treated currently will be denied as an ineligible expense.

> **Exception:** If services are for **Orthodontics,** monthly payments will be reimbursed only during the period of time services are being rendered.

Submit Claim-sign and date the claim form where indicated, attach the EOB from the other health plan,(if you have other coverage), attach a copy of the itemized bill or invoice, attach evidence of payment, and then submit all to Flex Administrators via one of the following methods:

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3980 Chicago Drive-Suite 230
Grandville, MI 49418

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Fax: (616) 454-6090
Phone: (616) 456-7908

Please feel free to contact HR/Benefits at (616) 234-4175 or (616) 234-4052 with any questions or, if you need additional clarification on any related area.