TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

BlueCross BlueShield of Texas

Claim Form for TRS-ActiveCare Member Rewards Limited Purpose Health Care Account (HCA) Expenses

If you've completed a rewards-eligible service or procedure, and have incurred vision or dental expenses, you can submit this form for reimbursement. Only vision and dental expenses are eligible for rewards. If you have any questions, call a Personal Health Guide at **1-866-355-5999,** available 24 hours a day, seven days a week.

Please read and follow the instructions below:

- In print, complete all information below.
- Complete the **Participant Information** list and separate expenses by individual family members, if needed.
- Attach the documentation:
  - Original receipt for care
  - Original receipt of purchase
- Keep copies of this form and other documents for your files. The form and receipts will not be returned.
- Send the completed claim form and supporting documents to:

Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

Participant Name (First and Last): ____________________

Participant Address: ____________________

Identification Number (as it appears on your BCBSTX ID card): ____________________

Group Number (as it appears on your BCBSTX ID card): ____________________

Participant Information

Participant Name: ____________ Participant Date of Birth (MM/DD/YYYY): ____________ Date (MM/DD/YYYY): ____________

Reimbursement For: ____________ Reimbursement Amount: $ ____________

Participant Name: ____________ Participant Date of Birth (MM/DD/YYYY): ____________ Date (MM/DD/YYYY): ____________

Reimbursement For: ____________ Reimbursement Amount: $ ____________

Participant Name: ____________ Participant Date of Birth (MM/DD/YYYY): ____________ Date (MM/DD/YYYY): ____________

Reimbursement For: ____________ Reimbursement Amount: $ ____________

Participant Name: ____________ Participant Date of Birth (MM/DD/YYYY): ____________ Date (MM/DD/YYYY): ____________

Reimbursement For: ____________ Reimbursement Amount: $ ____________

Patient Certification: I certify the above information is correct and that the expenses for which reimbursement is requested have been incurred and have not been reimbursed and are not reimbursable under any other health plan coverage. I understand that I am required to submit, in addition to this claim form, an original receipt. I further declare that I have not and will not deduct these expenses on my federal, state or local income tax returns.

____________________ ____________________

Participant Signature Date (MM/DD/YYYY)

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