TRS ActiveCare
TEACHER RETIREMENT SYSTEM OF TEXAS

BlueCross BlueShield of Texas

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

After your medical claim is submitted for Member Rewards, Blue Cross and Blue Shield of Texas (BCBSTX) determines its financial responsibility to the provider. This process is referred to as claims adjudication. As part of this adjudication process, your Member Rewards' funds are applied toward your future coinsurance or copays. Most medical services are adjudicated automatically, while most prescription drugs will require the completion of this form. If you need reimbursement that does not occur automatically as part of the adjudication process, please complete this form. Some over-the-counter (OTC) drugs and medicines, excluding insulin, will not be reimbursed unless you have a prescription from your Primary Care Provider. If you have any questions, please 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, please complete all information below.
- Complete the **Participant Information** list and separate expenses by individual family members, if needed.
- Attach the documentation:
  - Receipt for care
  - Receipt of purchase
  - Receipt for prescription
- 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):________
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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 that 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.

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Participant Signature Date (MM/DD/YYYY)