Capital

An Independent Licensee of the Blue Cross Blue Shield Association

HEALTH PLAN DEDUCTIBLE/TAX LIMIT VERIFICATION FORM

Use this form to verify that your medical deductible/tax limit has been met and to remove the limited status from your personal spending account.

Account Holder Information (please print)

Last Name | First Name | Middle Initial

Street Address

City | State | Zip

Email address | Employer's Name

Spending Account ID

S A

Social Security # (if SA# is not known)

Daytime Phone

Health Plan Deductible/Tax Limit Information (please print)

All fields in this section must be completed. If information is missing, the personal spending account will remain limited until all information is received.

Health Insurance Carrier Name: **Capital Blue Cross**

Health Insurance plan is:

- ☐ Individual Health Plan
- ☐ Family/Dual Coverage Health Plan

The health plan deductible/tax limit has been satisfied for the plan year _____ (year) as of _____ (date).

- ☐ I am attaching an explanation of benefits or some other documentation from my health insurance carrier that is proof of the deductible/tax limit being met.
- ☐ In the absence of an EOB or other documentation, I have a signature from my health insurance carrier below certifying that the deductible/tax limit has been met.

Health Insurance Carrier Representative Signature: _____ (person completing this form)

Signature Date: _____ Phone Number: _____

Account Holder Signature

I certify that the information listed above is true.

_____ Account Holder Signature

_____ Date

Questions? Call Member Services at 877.293.7041.

Send via secured email only:
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