Please keep a copy of this form and the certificate of completion for your records. Originals will not be returned.

AutoNation

MSRP BIOMETRIC PHYSICIAN REIMBURSEMENT FORM

If you visited your doctor because you have a medical condition that makes it inadvisable to be screened or you are submitting the MSRP Physician Results form in lieu of being screened at a Quest lab, and you incurred an out of pocket expense for your doctor's visit, please complete this form to be reimbursed for your office visit. Please fax/e-mail the completed form and a copy of the receipt showing what you paid for the office visit by the deadline. Additionally, see the next page for claim reimbursement instructions.

SECTION A. INFORMATION ABOUT YOU

PLEASE PRINT
Last Name: ______________________ **First Name:**______________________

Your Address: ____
Street, City, State, Zip Code

Last Four of Your Social Security Number: ☐☐☐☐ (Form cannot be processed without this information.)

Your Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Required in order to reach you in the event that this form is incomplete or incorrectly filled out.)

SECTION B. TO BE COMPLETED BY PARTICIPANT (FOR REIMBURSEMENT OF THE OFFICE VISIT)

In order **to receive reimbursement** for this physician office visit, please complete the information below and fax or e-mail the form with a copy of your office visit receipt that includes: your name, date of service, description of services (i.e. office visit, lab services, etc.), physician's name and amount you paid after insurance.

Date of Office Visit: ________/________/________ Office visit for which you are requesting reimbursement
Month Day Year

Amount Paid For Office Visit: $____________ This amount should match the amount listed on your receipt. AutoNation will reimburse you for the cost of this office visit. You are responsible for any additional ancillary charges related to this visit.

Any person who knowingly files a false statement in order to obtain healthy credits or submits any information in conjunction with this affidavit containing fraudulent, false, misleading, incomplete or deceptive information, (which may be considered an intentional misrepresentation of material fact) may result in being ineligible for such benefit credit (in addition to repayment of the credits received in the Plan Year); and may be considered to have committed a fraudulent or criminal act. These actions may be subject to prosecution under state and/or federal law. "I certify that the facts, as indicated above, are true and correct to the best of my knowledge."

Your Signature:______________________________ **Date** ________/________/________
Month Day Year

SECTION C. TO BE COMPLETED BY THE PHYSICIAN (MD OR DO ONLY*)

*If you are seen by a Nurse Practitioner or Physician's Assistant, the Physician's Tax ID Number and License # must still be listed on the form.

Patient's Last Name: ______________________ **First Name:**______________________

CHECK ONE: ☐ **AutoNation Employee** ☐ **Spouse of an AutoNation Employee**

Date of Last Visit (Most Recent): ______/______/______
Month Day Year

Physician Name (Print): ______________________ **Physician Degree:** ______________

Specialty: ______________ **Tax ID Number:** ____________ **Doctor's License Number:** ____________

Physician's Address:____
Street, City, State, Zip Code

Telephone Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ **Fax Number:** ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

A person who knowingly files a false statement to assist an individual in obtaining health benefit credits or submits any information in conjunction with this certification containing fraudulent, false, misleading, incomplete or deceptive information may be considered to have committed a fraudulent or criminal act. These actions may be subject to prosecution under state and/or federal law. " I certify that the facts, as indicated above, are true and correct to the best of my knowledge."

Physician Signature:______________________________ **Date:** ________/________/________
Month Day Year

AutoNation

MSRP BIOMETRIC PHYSICIAN REIMBURSEMENT FORM INSTRUCTIONS

If you visited your doctor because you have a medical condition that makes it inadvisable to be screened or you are submitting the MSRP Physician Results form in lieu of being screened at a Quest lab, and you incurred an out of pocket expense for your doctor's visit, please complete this form to be reimbursed for your office visit. Please fax/e-mail the completed form and a copy of the receipt showing what you paid for the office visit by the deadline.

REIMBURSEMENT INSTRUCTIONS

In order to receive reimbursement for this physician office visit, please:

1. Complete Section B of this form.
2. Submit the completed form with your office visit receipt. AutoNation will reimburse you for the cost of a routine physical only. The receipt must include your name, the date of service for your office visit, a description of services (i.e. office visit, lab services, etc.), the physician's name and amount you paid after any insurance reimbursement.
3. If you are currently enrolled in an AutoNation medical plan, you must also submit the Explanation of Benefits provided by your insurance carrier or a detailed summary of what the physician is billing for. AutoNation will reimburse you for the cost of a routine physical only. Any lab work, x-rays or other procedures will not be reimbursed and you will be responsible for the cost of those services.

To view your specific deadline, visit KnowYourBenefits.org. Click "Benefits Enrollment & Changes," then in the Enroll in Your Benefits section, click "Enroll Now", then login to the enrollment website.

RETURNING YOUR FORM

Upload Instructions	1. Go to KnowYourBenefits.org. Click "Benefits Enrollment & Changes," then in the Enroll in Your Benefits section, click "Enroll Now", then login to the enrollment website 2. Click on the "Upload MSRP or Working Spouse Surcharge forms" tile 3. Select "MSRP Physician Reimbursement Form" 4. Click "Browse" to find your document on your computer 5. Click "Upload"
Mailing Address	The Benefit Connection PO BOX 64116 The Woodlands TX 77387-4116
Fax Number	Fax number: 847-883-8251