

Health Reimbursement Arrangement Claim Form

Date: _____
 Fax- # of Pages: _____

Filing Instructions

1. Submit a completed and signed claim form. Incomplete or unsigned forms will be returned.
2. Attached the Explanation of Benefits (EOB) from your primary health insurer or prescription receipt from your pharmacy detailing how they processed your claim. Cash register and/or credit card receipts will not be accepted.
3. *If you request payment to your provider*, attach the invoice from your provider. Please verify that your provider's invoice requests payment that is equal to what the insurer's EOB states you owe. If the invoice and EOB conflict, the claim will be paid based on the EOB and payment will be made to the employee.

Step 1: Personal Information

Employer Name: _____
 Employee Name: _____ SSN: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Phone Number: _____ Email Address: _____
 Check if this is a new address

Step 2: Payment Instructions (Check One)

Please pay employee. Please pay provider. (Provider invoice and EOB must be included.)

Step 3: Expense Reimbursements Requested (Limit of 4 Per Claim Form)

	Expense #1	Expense #2	Expense #3	Expense #4
Date of Service	_____	_____	_____	_____
Patient Name	_____	_____	_____	_____
Deductible Amount \$	_____	_____	_____	_____
Patient Relationship	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child

Step 4: Acknowledgement and Signature

To the best of my knowledge and belief, my statements in this form are complete and true. I am claiming reimbursement only for eligible expenses incurred by my legal dependents and/or myself incurred during a period while the undersigned was covered under the HRA plan. I certify that these expenses have not been and will not be reimbursed from any other health plan coverage.

Employee Signature: _____ Date: _____