HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

INSTRUCTIONS: FAILURE TO COMPLETE ALL SECTIONS OF THE FORM WILL DELAY PROCESSING OF YOUR CLAIM. Complete all personal information. Indicate the incurred date(s) of the expense, Provider name/Dependent information, and the dollar amount eligible for processing. Attach copies of the documentation (Explanation of Benefits (EOB), etc.) that will include the incurred date/service date (not paid date), and a description of the service provided. Please sign the claim form below, attach copies of appropriate documentation, and forward by fax OR mail (not both) for processing.

Employer Name_____

Employee Name _____ Daytime Phone (____)_____
Last First Middle Initial

Employee ID (assigned by Benefits Design) or Social Security Number (last 4 digits) _____

Employee Address _____ ☐ **Check if new address**
Street City State Zip Code

ADULT CHILD CLAIM* (Check if Applicable)		**SERVICE DATES START DATE-END DATE**		**AMOUNT**	**PROVIDER NAME/ DEPENDENT NAME** (i.e. XYZ Hospital/John)	**For Office Use Only** HRA $ to be paid	Office Use
❑	1.	_____ -	_____	_____	_____	_____	_____
❑	2.	_____ -	_____	_____	_____	_____	_____
❑	3.	_____ -	_____	_____	_____	_____	_____
❑	4.	_____ -	_____	_____	_____	_____	_____

TOTAL _____

***ADULT CHILD CLAIMS ONLY: HRA Reimbursements are only issued to the participant, however, if additional information is required to process the claim for an adult child and you wish to have this request directed to an address other than the participant address above, please provide that address in the space below:**

_____
Name of Adult Child Street City State Zip Code

I certify that the above information is correct and that the expenses claimed were incurred by me, my spouse, or by my eligible dependents after my effective date of coverage in my employer's benefit plan. The submitted expenses are valid Qualified Medical Expenses as defined in the Plan Document. I further certify that none of the expenses filed in the HRA plan have been or will be reimbursed by any other source and that I have not and will not claim these expenses on my personal income tax return. I acknowledge that if my coverage under the HRA does not constitute permitted non-HDHP coverage I am not eligible for Health Savings Account (HSA) contributions while covered under the HRA plan.

EMPLOYEE SIGNATURE _____ **DATE** _____

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