Employer-Sponsored
Health Reimbursement Arrangement (HRA)
Claim Form

Employer Name_____ Group Number_____

Employee Name_____ Last 4 of SSN_____

Street Address _____

City, State, and Zip_____

Daytime Phone_____ Email_____

[ ] Check this box if address change [ ] Electronic Deposit Information on file

Plan Year: January 1st – December 31st 20__13__

Important Note: A complete copy of the Explanation of Benefits (**EOB**) from your group health insurance company must accompany each claim.

Patient Name: _____ **Claim Total: $** _____

AFFIDAVIT: This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year either for myself or covered eligible dependents. I certify that these expenses have not been reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Health Reimbursement Arrangement (HRA) to be reduced by the amount requested.

Employee Signature_____ Date_____

CLAIMS MAY BE SUBMITTED VIA FAX, MAIL OR EMAIL

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