

# HRA Reimbursement Request Form

Employer Name

Member ID#

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Member Name

Member Daytime Phone #

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Member Address

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City

State

Zip

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## HEALTH CARE EXPENSES

Patient Name	Relationship to Member	Type of Expense	Start Date of Service	End Date of Service	Total Charge	Amount to Be Reimbursed
Note: Include proof of expenses and explanation of why they are not covered by the insurance plan. <span style="float:right"><b>TOTAL \$</b></span>						

### PROOF OF EXPENSES MUST INCLUDE:

For Medical	For Rx
Patient's Name	Patient's Name
Name and address of provider	Amount charged
Amount charged	Date the prescription was filled
Type of Service	One of these: Name of medication OR the National Drug Code (NDC) number OR the word "co-payment" printed on the receipt
Date of Service	

Note: Provide an itemized receipt for each amount requested, or your request will be denied. Please dont send credit card receipts, cashed checks or copies of checks. They are not acceptable receipts for reimbursement.

Signature of Service Provider

Date

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I hereby request payment from my health reimbursement arrangement for the expenses listed above. I certify that I have not been reimbursed for these expenses from any other health plan. I understand that any expenses reimbursed may not be used to claim any federal income tax deduction or credit. I hereby authorize a deduction from my flexible spending account.

Signature of Member

Date

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