Instructions: You may complete the necessary information by typing it in on this screen and then print the form or you can print the blank form and complete it by hand.
Note: Claims require your signature, so the form must be signed and submitted by mail, or fax with all required attachments (or scanned, and emailed).

HRA Reimbursement Claim Form

Employer Name ______________________________

Employee Name ______________________________ SSN ______________

Mailing Address ______________________________

Request for Medical Expense Reimbursement

Date Incurred	Service Provider (Physician, Hospital, etc)	Expense/ Service Description	Incurred by whom	Amount Requested

PLEASE ATTACH CORRESPONDING EXPLANATION OF BENEFITS (EOBS)
YOU MUST INCLUDE THE INSURANCE CARRIERS EOBs.

Total Claim $ ________

I request payment from the reimbursement account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I further certify that I have met all the requirements for eligible medical expenses. I understand that reimbursed expenses cannot be claimed as a deduction on my personal income tax return.

Employee Signature ______________________________ **Date** ______________

Eligible Medical Expenses:
In general, you may be reimbursed for an expense for "medical care" (as defined in Internal Revenue Code section 213(d)) that has not and will not be reimbursed by any other source and has not and will not be deducted on your income tax return. Examples of eligible expenses include deductibles and co-insurance. If there is any question on items eligible for reimbursement, consult with your employer's human resources department for clarification.

Submit to: Benefit Solutions, Inc. PO Box 385 Taylorsville, NC 28681
Phone 828.632.4970 Fax 828.632.4969 Email: tpasecure@benefitsus.com