



**APPLICATION FOR HEALTH REIMBURSEMENT ARRANGEMENT (HRA)**

**Employee Name** \_\_\_\_\_

**Member ID** \_\_\_\_\_ **Group Number** \_\_\_\_\_

To submit a claim to your Health Reimbursement Arrangement you must:

1. Complete this form.
2. Attach copy of bill or receipt from the provider of service for all eligible expenses.  
Each EOB, bill or receipt must contain the following information:  
 \_ Name of person receiving service                      \_ Amount charged  
 \_ Date of service    \_ Name of provider rendering service  
 \_ Type of service
3. Attach the Explanation of Benefits from ALL insurance carriers for expenses that are covered under any group medical and pharmacy plan.
4. Retain copy for your records.

**ITEMIZATION OF SUBMITTED EXPENSES**

Amount of Claim	Patient's Name	Relationship to Employee	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I certify that either I and/or my eligible dependent(s) have incurred these expenses and have not been previously reimbursed and are not eligible for reimbursement under any other plan.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_