Health Reimbursement Account (HRA)
Request for Medical Expense Reimbursement

administrative solutions that work

Company Name:		Group Number:	

To request reimbursement of a medical expense, you must complete this form and attach an Explanation of Benefits (EOB) or prescription receipt that clearly indicates:(a) that the medical expense has been incurred; (b) the amount of the expense; and (c) that the medical expense has not been reimbursed or is not reimbursable under **any** other health plan coverage. If you and/or your dependents are covered by more than one health plan, you must submit an EOB from *both* plans along with this completed form.

Cancelled checks are not acceptable in place of an EOB.

Eligible Expenses:

- ☐ Medical plan charges applied to the deductible
- ☐ Prescription drug charges applied to the deductible
- ☐ Medical plan co-payments
- ☐ Prescription drug co-payments
- ☐ Medical plan out-of-pocket expenses
- ☐ Dental expenses
- ☐ Vision expenses
- ☐ Insurance Premiums
- ☐ Other

Annual Reimbursement Amount:

- ☐ $ Individual
- ☐ $ Family

☞ Important Note: Complete one Request for Medical Expense Reimbursement form per family member. ☜

Healthcare Plan:	☐ Yes	☐ No	☐ PPO	☐ HMO	☐ Other	Plan Name: _____
Secondary Health Plan:	☐ Yes	☐ No	☐ PPO	☐ HMO	☐ Other	Plan Name: _____
Dental Plan:	☐ Yes	☐ No	☐ PPO	☐ DMO	☐ Other	Plan Name: _____
Vision Plan:	☐ Yes	☐ No	Plan Name: _____			
Flexible Spending Acct:	☐ Yes	☐ No	Plan Name: _____			
Employee's Name:	_____					
Patient's Name:	_____					
Address:	_____ Street		_____ City	_____ State	_____ Zip	
Employee Ph. Number	_____		Employee Medical Id Number:	____-____-____		

TOTAL REIMBURSEMENT REQUESTED: $_____

_____ *Signature*

_____ *Date*

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