Employer Name ________________________________

Health Reimbursement Arrangement

Reimbursement Request Form

PERSONAL DATA (Please Print)

Name	SS# (Last four digits only) XXXX-XX-
Home Street Address	Address Change ☐ YES ☐ NO
City	State ZIP
Work Phone ( )	Email:
Home/ Cell ( )	I prefer to be contacted by: (please circle one) Email Work Phone Cell Phone Mail

You must provide an Explanation of Benefit showing the date of service, description of the service, name of the provider, and name of the patient from your Insurance Provider. If this form is incomplete your claim could be denied. Print or type the information requested and then sign and date this form.

Claim Line Number	Name of Medical Provider (Doctor, Lab, Hospital, etc.)	Date(s) of Service	Patient Name	Relationship (Self, Spouse, Child)	Member Responsibility Amount	General Medical Expense Description
1					$	
2					$	
3					$	
4					$	
5					$	
6					$	
7					$	
8					$	
					TOTAL MEDICAL AMOUNT REQUESTED:	

Please submit the documentation in order as listed on this form.

*Claims for future services will not be accepted.

I request payment from my Health Reimbursement Arrangement (HRA) account as indicated above for the expenses listed that were incurred during the plan year by myself and/or my eligible dependents. I certify that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while I was enrolled in the Employer's HRA with respect to such expenses. I certify that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I certify that these expenses will not be claimed as an income tax deduction. I fully understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided and that unless an expenses for which reimbursement is claimed is a proper expense under the plan, I may be liable for payment of all related taxes includeding federal, state, or local income tax on amounts paid from the plan which relate to such expense.

Employee signature ____ Date ______________________

Submit your claim by FAX to 877-227-1753

Or send a secure email to hradocs@empower3cfh.com