HRA Reimbursement Form

1. Employee information

Employee name (First, MI, Last):		Member ID:		
Street Address:		City:	State:	Zip:
Telephone:	Date of birth:	Employer:		

2. Health care expenses

#	Patient's Name	Date of Service		Type of expense to be reimbursed (deductible, coinsurance, other)	Provider Name	Amount to be reimbursed
		From	To			
1						
2						
3						
4						
5						
6						
					TOTAL	

3. Required documentation

For each claim above, please attached the following:

- A copy of the primary insurance carrier's Explanation of Benefits
- A copy of any provider bill including provider name, address and Tax ID
- If no provider bill is available, please complete the form below (claim numbers above correspond with numbers below)

#	Provider Name	Tax ID	Provider Address (must include street address, city, state and zip code)
1			
2			
3			
4			
5			
6			

I certify that the amounts herein requested for reimbursement have been actually incurred as qualified expenses during a period while the undersigned was covered under the plan and have not, cannot and will not be reimbursed from any other benefit plan deducted on my income tax return, nor were they previously submitted for reimbursement under this Plan. I agree to provide supplemental information to process this claim as requested by the Plan Administrator. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim.

Signature _____ **Date** _____

Claims Department • 8220 Irving Road • Sterling Heights, MI 48312-4621
Phone: 586-693-4300 • Fax: 586-693-4820 • www.abs-tpa.com

abs AUTOMATED BENEFIT SERVICES