



HRA REIMBURSEMENT FORM

EMPLOYER: _____ TELEPHONE: _____

EMPLOYEE NAME: _____ SOCIAL SECURITY #: _____

ADDRESS:

Check if address is different from last claim submitted

DATE OF EXPENSE	NAME OF PERSON FOR WHOM EXPENSE WAS INCURRED	AMOUNT OF MEDICAL EXPENSE
		\$
		\$
		\$
		\$

Total Request:

\$

HRA Expense Reimbursement Guidelines:

- ✓ Acceptable documents to attach to this reimbursement form are: (1) professional bills or receipts that include the provider of service, type of service, date of service, charge for the service; (2) Insurance Company Explanation of Benefits; (3) Pharmacy statement that includes Rx number and name of prescription; (4) OTC reimbursements must include cash register receipt with name of item, date purchased, and amount of item.

- ✓ Unacceptable documents include: (1) Cancelled checks; (2) credit card receipts; (3) bill or receipt that only show a balance forward, previous balance or a payment due.

I certify that these expenses have not been reimbursed and I will not seek further reimbursement for them under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expense(s) for which I am being reimbursed may not be used to claim any federal income tax deduction or credit. The expense(s) submitted is/are either for myself, my spouse or my dependent as defined in Code Section 152.

Employee's Signature:	Date:
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Always keep a copy of your claims submitted for your records

Mailing Address:

HealthComp Administrators
 Attn: Flex/HRA Dept.
 P.O. Box 45018
 Fresno, CA 93718

Fax Number: (559) 499-2045

Telephone Number: (559) 499-2450 or (800) 442-7247; then Press 3 for Customer Service

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