HEALTHCARE REIMBURSEMENT ACCOUNT CLAIM FORM

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL. IF POSSIBLE, PLEASE INCLUDE YOUR HEALTH PLAN EOB OR RECEIPT)

FAX:
(603) 773-4430

Mail to:
EBPA
Attention: HRA Reimbursement Accounts
P.O. Box 2000
Exeter, NH 03833-2000

HRA REIMBURSEMENT REQUEST

Please use black or dark blue ink. Do not use highlighter or gel pens. Do not include dependent care or flexible spending account expenses on this form.

Company: ____

Employee Name: ____

SSN: ____

EXPENSE FOR:		DATES OF SERVICE:		TOTAL BILL (ATTACH COPY OF EOB)	AMOUNT APPLIED AGAINST DEDUCTIBLE	AMOUNT OF REIMBURSEMENT DUE
FIRST NAME	RELATIONSHIP	FROM	TO			
				TOTAL DUE EMPLOYEE:		

IF POSSIBLE, PLEASE PROVIDE DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. YOU MAY ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. IF FURTHER DOCUMENTATION IS FOUND TO BE NECESSARY- YOUR REIMBURSEMENT MAY BE DELAYED.
I certify that these statements are true and that the claimed expenses cover only me, my tax dependents, and/or spouse (if filing taxes jointly). I further understand that expenses reimbursed by an HRA may not be reimbursed by a flexible spending account or claimed on my individual tax return at the end of the year.

Employee Signature: ______________________________
Date: ______________________________________

☐ Check here if your address has changed. Please list below.

New Address: ______________________________
____
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