Request for Reimbursement from HRA Account Claim Form

beneliance

Employer Name_____

Employee Last Name _____ First Name _____ Middle Initial ____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone (_____)_____ Work Phone (_____)_____

E mail Address (if any)_____

❒ Please check if new mailing address ❒ Please check if new email address

Your insurance carrier's Explanation of Benefits (EOB) for each expense claimed must accompany this form.

Medical Expense Claims

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim. Use a copy of this form if you need more space. Use the "Dually Covered" column to indicate that the claim being remitted is dually covered. *All information below must be completed.

Date of Service	Patient Name	Patient SS#	Relationship	Dually Covered	Name of Provider	Description of Service	Amount
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
							$
						Total:	$

Employee's Certification for Disbursement

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:_____ **Date:** _____ /_____ /_____
mm/dd/yy

Beneliance | PO Box 55068 | Little Rock, AR 72215
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For fastest reimbursement, please use the myRSC app or email to vtsupport@datapathadmin.com