Health Reimbursement Arrangement (HRA)

Reimbursement Claim Form

Employer: _____

Employee: _____

Phone: _____

Employee SSN Last 4 digits: XXX-XX- _____

E-mail: _____

Deductible/Co-Insurance Medical Expense Claims

Date Expense Incurred (mm/dd/yy)	Name of Service Provider (doctor, hospital)	Expense Description	Person for Whom Expense Incurred	Deductible Amount
➡ *Attach your **E**xplanation **O**f **B**enefits and submit with this claim form*		**Total Healthcare Expense Claim**		$

Please note: You must submit a copy of your Explanation of Benefits form to be reimbursed.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's **HRA** Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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 which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ Employee Signature

_____ Date

***Note: Form must be signed in order to process the claim.**

HRA Claim Filing Procedures...

How To File A Claim

- Complete all information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.
- You must sign and date the claim form.
- Attach a copy of your **E**xplanation **O**f **B**enefits **(EOB)** which supports each reimbursement request. *Please include all pages (front and back) of the **EOB**.* **The EOB form is required for all deductible claims.**

Claim Form

If you **mail** your claim with EOB's, remember to keep a copy of the claim form and supporting documents for your records.

If you **fax** your claim with EOB's, please remember to keep the original claim form and supporting documents for your records.

Where To Send A Claim

Mailing Address:	Davevic Benefit Consultants, Inc. 902 South Center Street P. O. Box 976 Grove City, PA 16127
Fax:	724-458-4464
E-mail Attachment:	flexcontact@davevic.com
Phone:	724-458-7255 or toll free 800-854-4099
Online Account Access:	www.davevic.com