

HEALTH REIMBURSEMENT ARRANGEMENT Claim Sheet

CLAIMS FOR _____
Employee Name

EMPLOYER: _____

This is to certify that I have incurred expenses in the amounts shown below that qualify for reimbursement under the provisions of my employer's Health Reimbursement Arrangement (HRA).

HRA REIMBURSEMENT EXPENSES:

Unreimbursed Health Expense \$ _____

I am attaching documentation from my service provider that shows date(s) and type(s) of service (an EOB, explanation of benefits form from your insurance provider). I certify that these expenses have been incurred and have not been reimbursed, or are not reimbursable, under any other health plan coverage. Since these expenses are being reimbursed by my employer, they may not be claimed on my income tax filings at year end.

Date Employee Signature

- Mailing Address for Reimbursement Check
- Change of Address for Reimbursement Check

City State Zip

Email Address: _____