Employee Health Reimbursement Account (HRA) Claim Form

Company Name: _____

_____

Employee First and Last Name

_____

Home Address (Street/City/State/Zip)

_____

Phone Number

HEALTH REIMBURSEMENT MEDICAL EXPENSE REIMBURSEMENT INFORMATION:
***Read instructions on following page before completing this claim form**

Date of Service	Name of Service Provider (doctor, facility, etc.)	Name of Person Receiving Service & Relationship to Employee (spouse, child)	Amount of Expense
Attach appropriate receipts, invoices and insurance carrier explanation of benefits and submit with this claim form.		Total Medical Expense Reimbursement Request	$

Reimbursement is payable to the Employee when Employee submits HRA claim form

I request and authorize you to furnish Stearns HR Compliance and Consulting, or its authorized representative, or to permit the representative to obtain a statement or review or make or obtain a copy, in whole or in part, of any or all information with respect to any illness or injury including but not limited to medical history, diagnosis, consultation, examination, prescriptions, treatments, operative procedures, X-rays, pathological findings or test you may have concerning me or my dependents. This information is to include alcohol abuse, substance abuse, or mental health records. The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under his/her employer's reimbursement plan with respect to such expenses and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. 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 local income tax on amounts paid from the Plan which relate to such expense. A photocopy of this authorization shall be as valid as the original.

_____

Signature of Employee Date Signed

For Office Use Only

Claim Number: _____

Health Reimbursement Arrangement (HRA) Employee Claim Filing Instructions

How To File A Claim:

- Complete all information on the claim form for each amount claimed for reimbursement. If you have multiple lines of reimbursement use a second claim form. You must fill out a claim form for each individual you are seeking reimbursement for (spouse, child, self).
- Make sure the claim does not include items for more than one calendar 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 comes from your primary health insurance carrier, EOB's can be accessed by going online or by calling the customer service number on the back of your health insurance member ID card.
- Attach copy of a bill, invoice, or billing statement which supports each reimbursement request and shows the date the service was incurred. These statements will need to match the EOB's.

Claim Form:

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

Where To Send A Claim:

Mailing Address:	Stearns HR Compliance and Consulting Attn: Claims Department P.O. Box 866 Sterling Heights, MI 48311
Phone:	(877) 6COMPLY
Email:	service@stearnshr.com