Health Reimbursement Account (HRA) Claim Form

Complete this claim form in its entirety, provide legible documentation as instructed, and sign below. Please print clearly.

Your Name (Last, First, MI)	Social Security No. or EID or PIN	Your Employer Name

Address	City	State	Zip Code

Health Reimbursement Account Claims

Please include appropriate documentation required by your employer plan with this completed claim form as follows:
If covered by insurance, provide the insurance payer's Explanation of Benefits Statement. If not covered by insurance, provide an itemized statement from the provider of care. An itemized statement must include the provider name/address, patient name, description of the type of service provided, date the service was provided (not when you paid or were billed), and the dollar amount. Prescriptions require the pharmacy receipt, pharmacy printout, or the mail-order itemized statement.

Note: Examples of unacceptable documentation include cancelled checks, credit card receipts, balance forward/amount due/paid-on-account statements, pre-treatment estimates or statements for future dates of service.

Date(s) of Service	Health Care Provider	Description of Expense	Patient Name	Relationship to You	Amount Requested	ASIFlex Use Only
					$	
					$	
					$	
					$	
					$	
					$	
					$	
				TOTAL	$ 0.00	

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's HRA Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source.

I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I 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 claim will only be processed with a completed and signed claim form and correct documentation.

SIGN HERE → → Employee Signature _____ Date _____

FAX TO:
1-877-879-9038
PAGE _____ OF _____
NO COVER PAGE REQUIRED

MAIL TO:
ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

QUESTIONS:
WWW.ASIFLEX.COM
ASI@ASIFLEX.COM