# Lebanon Valley College

**HEALTH CARE REIMBURSEMENT ACCOUNT CLAIM FORM**

Name: _____ Social Security Number: _____
(Last) (First) (M.I.)

Address: _____

_____

**Medical/Dental/Vision Expenses** (attach proof of your expense)

| Description of Eligible Expense | Incurred Date | Total Amount of Bill | Your Actual Cost (HCRA Claim) | Expense for: Name* |
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**If dependent, provide relationship and date of birth.*

## Your Authorization

I authorize the expenses written above, which are excluded from the Lebanon Valley College medical plan, to be reimbursed through my Health Care Reimbursement Account. I certify that, to the best of my knowledge, these expenses I am submitting qualify as eligible expenses under the Health Care Reimbursement Plan parameters. I further certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me, my spouse, or another member of my family.

_____ _____
Your Signature Date

## HOW TO SUBMIT A CLAIM

When you have health care expenses that qualify for reimbursement under the **Health Care Reimbursement Account (HCRA)**, follow these steps to submit a claim:

1. **Check to see that the health care expenses qualify for reimbursement or can be applied towards your deductible under your current health care plan.**

   * **If they can be applied towards your deductible or coinsurance**, submit them to your health care insurer as you would normally under that plan. After the claim is processed, you will receive an Explanation of Benefits (EOB) which will specify the amount that has been paid and those expenses left unpaid. The EOB will be the "proof of expense" needed to submit your claim for reimbursement under the HCRA.

   * **If they cannot be applied towards your deductible or coinsurance**, the original bill or paid receipt will be the "proof of expense" needed to submit your claim for reimbursement under the HCRA.

2. Fill out an **HCRA Claim Form** and attach your "proof of expense." A "Proof of Expense" **must** include the following information:

   - Provider Name
   - Patient Name
   - Date of Service
   - Type of Service
   - Cost of Service

3. Submit your completed HCRA Claim Form to the Payroll & Benefits Office.

4. Be sure to **keep photocopies** of the form and the attachments for your files

5. Claims will be processed **once a month**.

6. If you have any questions regarding this process, contact the Payroll & Benefits Office.