Health Reimbursement Arrangement (HRA) Claim Form

Employee Name	SSN (last 4 digits)
Address (To make an address change, please contact your employer)	Phone Number
Employer Name	Email Address

Notice

Reimbursement requests can be mailed or faxed. All requests received by Tuesday will be processed for reimbursement on Thursday.

Mail claims to: PayFlex, Attn. BlueFund Department
13511 Label Lane, Suite 201
Hagerstown, MD 21740
Fax to: 301.564.5192

All Medical and/or Pharmacy (RX) claim requests must be submitted to your insurance provider. Medical reimbursement request(s) will require an Explanation of Benefits (EOB) or itemized bill from the provider showing the provider name, expense description, date of service, amount paid and, if applicable, amount covered by insurance. **Credit card receipts, cancelled checks, and cash register receipts are not acceptable.** Pharmacy reimbursement request(s) will require a receipt showing the date of service, prescription (RX) name and number along with total amount. Please send only copies and keep originals for your records.

Health Reimbursement Arrangement

Please Indicate: ☐ NEW claim ☐ Resubmitted claim | Is this a grace period claim?: ☐ YES ☐ NO

Date of Service	Provider Name	Type of Service (Medical, RX, Over-the-Counter, Vision, Dental)	Amount Requested
		ENTER TOTAL:	$

I certify that these medical and/or pharmacy (RX) expenses have been incurred by me and/or my eligible dependents and are for the treatment of an illness, injury, trauma, or medical condition. The attached submitted expenses are not payable by any other plan and I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature (REQUIRED) _____ **Date** _____