BENEFIThelp Solutions

HRA Account
Reimburse Me Claim Form

Fax: 1-888-249-5058
Submit online at www.benefithelpsolutions.com
Ph: 503-219-3679 or 1-888-398-8057
PO Box 67230 • Portland, OR 97268

DO NOT USE A FAX COVER SHEET

ACCOUNT HOLDER INFORMATION

Member ID: _____ **Phone #:** ___ - ___ - ____
Member ID or last four digits of Social Security Number (not required)

Name: _____ _____
Last First

New Address? YES

Address: _____ _____
Street Apt.

_____ ___ _____
City State Zip

Email Address: _____

Employer Name: _____ **Group #:** _____ *(if known)*

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

1 _____
Name of Dependent / Self

_____
Name of Provider / Merchant

__ / __ / __ Service Date (MM/DD/YY)

$___,___.__ Amount Requested

2 _____
Name of Dependent / Self

_____
Name of Provider / Merchant

__ / __ / __ Service Date (MM/DD/YY)

$___,___.__ Amount Requested

3 _____
Name of Dependent / Self

_____
Name of Provider / Merchant

__ / __ / __ Service Date (MM/DD/YY)

$___,___.__ Amount Requested

$___,___.__
TOTAL THIS FORM

Please remember to submit your Explanation of Benefits from your insurance company.

Requesting Reimbursement
I am requesting **reimbursement** from my Health Reimbursement Arrangement for the above listed amounts. I certify these expenses are not covered or reimbursable from any other source, nor will I seek reimbursement for these expenses from any other source. I understand that I cannot use expenses reimbursed through the healthcare account as tax deductions. I further certify that the expenses submitted on this claim are for me and/or my qualified tax dependents as defined under Internal Revenue Code Section 152 (as amended by the Working Families Tax Relief Act of 2004).

Account Holder Signature: _____ **Date:** _____ **Total Number of Pages:** _____
Signature of spouse or dependents is not acceptable.