BENEFITthelp 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

☐ Check box if this is to offset previously submitted ineligible expense(s).

ACCOUNT HOLDER INFORMATION

Member ID: **Phone #:**

Member ID or last four digits of Social Security Number (not required)

Name:

Last First New Address?

Address:

Street Apt.

City State Zip

Email Address:

Employer Name: **Group #:**

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

1 _____ **$** _____

Name of Dependent / Self Service Date (MM/DD/YY) Out-of-Pocket Cost

_____ _____

Name of Provider / Merchant Product Description (if applicable)

2 _____ **$** _____

Name of Dependent / Self Service Date (MM/DD/YY) Out-of-Pocket Cost

_____ _____

Name of Provider / Merchant Product Description (if applicable)

3 _____ **$** _____

Name of Dependent / Self Service Date (MM/DD/YY) Out-of-Pocket Cost

_____ _____

Name of Provider / Merchant Product Description (if applicable)

Please remember to submit your Explanation of Benefits from your insurance company and/or a statement from an independent third party describing the service or product, the date of service or sale, the name of provider or vendor, and the amount of charge(s).

$ 0.00

TOTAL THIS FORM

Requesting Reimbursement

I am requesting **reimbursement** from my Health Reimbursement Arrangement (HRA) for the amounts listed above. To the best of my knowledge, my statements in this Reimburse Me Claim Form are complete and true. In addition, 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 HRA as tax deductions when filing income tax returns. I further certify that the expenses submitted on this claim are for me and/or my qualified tax dependents for health coverage purposes as defined under the Internal Revenue Code Section 152.

Account Holder Signature: _____ **Date:**_____ **Total Number of Pages:**

Signature of spouse or dependents is not acceptable.