HRA Claim Form

Today's Date: ____/____/____ # of pages: __________ Plan year 20__

❑ New Claim ❑ Resubmission of claim ❑ Response to claim denial

Employer Name:		Employee Name:
Address: ☐ Please check if change of address		
Social Security Number:	Union/Division:	Home Phone: Work Phone:

HRA/Deductible Reimbursement

Must include Explanation of Benefits from Medical Carrier

Date of Service	Employee, Spouse or Dependent	Type of Service (Office Visit, Lab, etc.)	Amount
1.			
2.			
3.			
4.			
5.			

Claim Total: __________

Please note the following procedures for requesting reimbursement:

1) Submit charges to Blue Cross either directly or through the doctor or hospital that provided the care.
2) Wait for an Explanation of Benefits Statement from Blue Cross.
3) If any of the charges are being applied towards your deductible you may submit them for reimbursement. This amount will be listed on your statement under the "Less Deductible" column.
4) When we receive your statement we will apply it toward your deductible with P&A. Once you meet your deductible with P&A, we will reimburse you the amount that you pay towards your deductible with Blue Cross. You will be responsible for paying the first $100 of charges per individual with a maximum of two deductibles per family. You will receive 100% reimbursement from P&A Administrative Services for any amounts above the $100 single and $200 family responsibility. The maximum reimbursement for single is $400 and family is $800.
5) When reimbursement is received, pay the doctor or hospital if you have not already done so.

***Expenses denied by Blue Cross for any reason are not eligible for reimbursement through P&A Administrative Services, Inc.**

****Only Blue Cross Explanation of Benefit Statements can be processed for reimbursement. Bills from the doctor or hospital are not acceptable.**

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my Health Reimbursement Account be reduced by the amount requested.

EMPLOYEE'S SIGNATURE____________________________ DATE____________

For HRA reimbursements, please fax claim form and EOB(s) to: (716) 855-7146

Or mail to: Flex Department, 17 Court Street, Suite 500, Buffalo, NY 14202-3204

Rev. 7/6/2011