



MedBen Group # _____

HRA REIMBURSEMENT REQUEST FORM

Employee Name: _____ SS#: _____

Address: _____

Instructions: Complete the information below for medical expenses incurred by you, your spouse or other eligible dependents, for which you request reimbursement under the Employers HRA Plan. You must submit an explanation of benefits (EOB) as proof of claim. Please sign and date the form. **Send this form along with your EOB to: MedBen, Attn: Specialty Services, 1975 Tamarack Rd. P.O. Box 1096, Newark, OH 43058-1096.**

	Expense # 1	Expense # 2	Expense # 3	EXAMPLE
Date Service Was Actually Provided				10-7-99
Name of Person Receiving Medical Service/ Relation to You	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<i>Jane Doe</i> <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Type of Service				<i>Eyeglasses</i>
Total Expense	\$	\$	\$	\$ 100.00
Amount Reimbursed Previously, or Paid/Payable under Another Plan	\$	\$	\$	\$ 0.00
Reimbursement Requested	\$	\$	\$	\$ 100.00

Total Reimbursement Requested \$ _____

To the best of my knowledge and belief, my statement in this HRA Reimbursement Request Form is complete and true. I certify that I or my family member has received the services described above on the dates indicated, that the expenses qualify as valid medical services under the Plan, and that I have not been reimbursed previously under the Employers Plan or any other health plan, nor do I expect any of these expenses to be reimbursable elsewhere. **WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud call 1-877-9FRAUD 9 (1-877-937-2839).**

Employee's Signature

Date

Required supporting documentation:

- A bill or receipt (**including date of service, name of patient, provider name-address, amount, and type of service**) from a doctor, dentist, pharmacy or other supplier;
- Explanation of benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by the medical/dental/vision plan(s) under which the employee or any eligible dependents are covered;
- Store receipts are acceptable **ONLY** for hearing aid batteries, contact solution and over the counter medications. The receipt **MUST HAVE** the following information printed on the receipt: **Store name, date of purchase, Product name and amount of product.**

Employees may not submit proof of payment in the form of a cancelled check or credit/debit card receipt unless it is accompanied by the other required documentation.