Group #

HRA REIMBURSEMENT REQUEST FORM

Please review your Employers HRA Plan Document for eligible expenses

EMPLOYEE INFORMATION	ML: 22
Employee Name:	PID #
Address, City, State, Zip:	Is this a new address? ______ Yes or No

Instructions: Complete the information below for qualified medical expenses incurred by you, your spouse or other eligible dependents, for which you request reimbursement under your Employers HRA Plan.

Send this form along with your substantiation to: MedBen, Specialty Services Unit, 1975 Tamarack Rd., P.O. Box 1096, Newark, OH 43058-1096 or you may fax to: (740) 522-7483 or email to: admin@medben.com

You must submit proper substantiation as proof of claim. Please sign and date the form.

Date Medical Care / Service Was Actually Provided	Person Receiving Medical Care / Service Relationship to You	Type of Service	Reimbursement Amount Requested
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
	____ Self ____ Spouse ___ Dependent		$
		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, flexible benefit plan, health reimbursement arrangement or health savings account nor will I seek reimbursement for any of these expenses 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).

Signature (Required):	Date: