

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Reimbursement Claim Form



Employer Name

Social Security Number

Name (Last, First, Middle Initial)

Email Address

Address (Street)

Phone Number

Address (City, State, Zip)

Check Here If New Address

Healthcare Expense Claims

DATE EXPENSE OCCURED (mm/dd/yy)	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	PERSON FOR WHOM EXPENSE OCCURED	NET AMOUNT
Attach appropriate EOB(s) and submit with this claim form.				Total Healthcare Expense Claim

Read Carefully: The undersigned participant in the plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the company's HRA plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim that is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan that relate to such expense.

Your Health Reimbursement Arrangement (HRA) plan limits the expenses that may be reimbursed to you to your deductible, or a portion thereof. Please read the Summary Plan Description for your HRA plan for additional information.

Employee Signature

Date

Note: Form must be signed in order to process the claim.

Instructions for Filing a Claim

Complete all information on the claim form for each amount claimed for reimbursement.

Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.

Attach copy of an Explanation of Benefits (EOB) that supports each reimbursement request and shows the date the service was incurred.

Claim Form

If you mail your claim with EOB's, remember to keep a copy of the claim form and supporting documents for your records.

If you FAX your claim with EOB's, please remember to keep the original claim form and supporting documents for your records.

Where To Send a Claim:



Mail: Nyhart
Claim Reimbursement
8415 Allison Pointe Boulevard, Suite 300
Indianapolis, IN 46250-4159

Email: support@nyhart.com

Fax: 1-888-887-9961

Phone: 1-800-284-8412
317-845-3539