Request for Deductible Reimbursement (HRA) Claim Form

Employer: ______________________________

Employee Name: ______________________________

Employee Address: ______________________________

Phone: ______________________________

☐ *Please Check Mark box if the above is a New Mailing Address*

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I CERTIFY THAT: the expenses for reimbursement requested from my account have been incurred by me, my spouse and/or eligible dependents, and were not reimbursed by any other plan that covers health benefits, including but not limited to any individual or group health insurance or any other health care flexible spending account, including coverage under a spouse's or dependents plan. I (or we) will not use the expenses reimbursed through this HRA account as deductions or credits when filing individual income tax returns.

Are you or any of your family members who are covered under your coverage enrolled in any Secondary Insurance private or governmental group or individual health plan or program for any of the Deductible Claims Attached?

YES ☐ **NO** ☐ *If "Yes" please indicate name of Secondary Insurance Carrier/Provider* ____________________

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE PLAN BY FILING A CLAIM WHICH CONTAINS OR CONCEALS FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT THERETO COMMITS A FRAUDULENT INSURANCE ACT. THIS IS A CRIME AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES. EMPLOYEES WILL BE FINANCIALLY RESPONSIBLE TO REPAY ANY HRA FUNDS ISSUED BY THE EMPLOYER'S PLAN IF FOUND TO BE FALSE.

Total Amount "DEDUCTIBLE Claims" submitted for Reimbursement: **$**______________________

(Co-Pays are Not Eligible for Reimbursement)

Employee Signature: ____ **Date:** ______ **/**______ **/**______

When filing HRA claims, please attach: **Highmark - Explanation of Benefits (EOB's)**

1) The EOB page(s) must contain: ***Claim Number, Date of Service and the Provider of Service***.
2) Only send EOB's with amounts recorded in the "***Your Deductible***" column. (There is no need to send EOB's w/Co-pays)
3) Include all the pages of the EOB Including the "***PATIENT BENEFIT SUMMARY***" section
4) Patient/Program Benefit Summary: Patient:
   Benefit Period:
   You have *"Satisfied $____ of your $____ individual/program in network deductible"*

To gain access to your EOB's go to www.HighmarkBCBS.com or call
The phone number # on the back of your I.D. Card

*** Reimbursements WILL NOT be processed without EOB's from HIGHMARK ***

Please Keep Copies of your Claims for Your Records - You do not need to forward a hard copy if you Faxed Claims

You may Mail or Fax your HRA Claims to:

401 Cranberry Street Suite 100 • Erie, PA 16507
Phone: 814-453-4357 • 800-673-2518 • Fax: 814-459-8600
Website: www.chreams.com