To: Erin Bishop
Fax: 1-614-880-0091
Or claims@cbaben.com

Date: ________________

Total pages sent:_______

EMPLOYER:

Heath Reimbursement Arrangement (HRA) Claim Form

(PLEASE PRINT LEGIBLY)

EMPLOYEE INFORMATION			
Name			
Address	City	State	Zip

How may we contact you during the day? Email____________________Phone/cell:____________________

- ✓ An Explanation of Benefits (EOB), front and back if applicable, must accompany this reimbursement request. In most cases you can get copies by downloading them from your carrier's website.
  - ❒ Check here if you also have a Flexible Spending/Medical Expense Account and want claims that are your responsibility paid from that account after the HRA payment.
- ✓ Please keep copies of supporting documentation for your records. We will not return what has been submitted.
- ✓ Reimbursements are processed on the second and last Friday of the month. Submit your request the Wednesday before to avoid claim delays.

Claims incurred in the plan year must be submitted within 90 days of end of plan year or within 90 days of date of EOB whichever is later.

CERTIFICATION ***Please read carefully!***

I certify that the following is true:

1. The expenses attached were incurred by me and/or my eligible dependents and qualify for reimbursement.
2. The expenses are not eligible for reimbursement by any insurance plan. I understand seeking reimbursement for the same claim from two different sources (double dipping) is considered fraud.
3. I have not and will not deduct the expenses on my Federal Income Tax returns.

Employee Signature	Date

Mail, fax, or email this form with accompanying documentation to the numbers listed above. If submitting scanned documents, please ensure they are saved and sent in an Acrobat file.

Questions? Contact: **CBA Benefit Services at 866-880-0068 or claims@cbaben.com**
73 E. Wilson Bridge Rd #B6 Worthington, OH 43085