HRA Reimbursement Request Form

All information is required to process your claim:

PERSONAL INFORMATION	
Employer's Name	**Email Address**
Employee's Name	**Employer Employee ID**
Employee's Social Security Number (Last 4 Digits of SSN)	**Daytime Phone Number**

HRA Claim reimbursements require you to submit an ***Explanation of Benefits (EOB) Statement*** (if you are enrolled in a HRA plan that requires you to first meet the group health plan's deductible before the HRA plan will reimburse). The EOB must be from your insurance carrier which will include the provider's name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility. List the EOB amount for the person who you are claiming an expense for, ABA will determine the amount of reimbursement after any applicable deductible amount has been meet.

If your HRA plan does not require you to first meet a group health insurance deductible, then list the Out-of-Pocket Expense in the EOB Amount column.

HEALTH CARE EXPENSES					
Patient Name	**Relationship**	**Age**	**Date of Service**	**Type of Service**	**EOB Amount**
1.					
2.					
3.					
4.					
5.					
				Total:	

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Health Reimbursement Account, nor are reimbursable from any other source. I hereby authorize American Benefit Administrators, LLC. to obtain necessary information from all physicians, hospitals, employers, and all other agents to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Employee Signature **Date**

Return completed forms by email, fax, or mail to:
claims@americanbenefitadministrators.com | Fax: (866) 734-4777 | PO Box 380844 Birmingham, AL 35238
Phone: (866) 742-4900 | www.americanbenefitadministrators.com