

# HRA CLAIM FORM



Today's Date:  No. of Pages:  Plan Year:

New Claim       Response to Claim Denial

Name:

Address:

City:  State:  Zip Code:

Work Phone:  Home Phone:  SSN

Health Reimbursement Arrangement (HRA)      Total Amount Requested:

*Minimum check reimbursement is \$25.00; minimum reimbursement for direct deposit is .50 cents.*

*Must enclose Explanation of Benefits (EOB) from insurance carrier showing date of service, services rendered, provider of service and amount paid. Prescription claims do not require an EOB.*

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Rx, co-pay, dental expense)	Service Provider Number/ Rx Number

*I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been reimbursed under any other health plan. Furthermore, I will not seek reimbursement of the expenses under any other health plan.*

Employee Signature:  Date:

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## Claim Submission Guidelines

- Please number each receipt according to its order of appearance on this form
- IRS guidelines do not consider cancelled checks as valid documentation
- Previous balances are not acceptable
- All reimbursements will be made payable to the employee

Send completed claims via fax or mail to P&A Group.

FAX: Toll-free (877) 855-7105 or (716) 855-7105

MAIL: Flex Department

17 Court Street, Suite 500

Buffalo, NY 14202

## P&A Group Customer Service Information

Customer service representatives are available Monday - Friday, 8:30AM - 10:00PM ET.

WEBSITE: [www.padmin.com](http://www.padmin.com)

TOLL-FREE: (800) 688-2611