Health Reimbursement Arrangement Reimbursement Request Form

PLEASE PRINT

PRECISION ADMINISTRATORS, INC • EST. 1988

XXX-XX-

Last Name First Name M.I. SocialSecurity Nbr (Last 4 Digits Only)

Address:_____

Street City State Zip

_(_____)_____ _____(_____)_____

Home Phone Employer Name Work Phone

☐ Check box if this is a new address.

Acopy of the Explanation of Benefits (EOB) OR a letter received from your health insurance plan*MUST *accompany this completed form in order to process your HRA reimbursement request and show proof of deductible met.

Date of Expense or EOB	***Name ofCovered Participant***	***Relationship to Employee*** (Self, Spouse, Child)	***Type of Expense***	***Total Expense***
				$
				$
				$
				$
				$

Reimbursement Total ***$_____***

By my signature below I certify that I and/or my spouse and/or dependent child incurred expenses detailed above and are eligible for reimbursement under the above employer's Health Reimbursement Arrangement. I have attached a true and accurate Explanation of Benefits or other acceptable documentation. I also certify that expenses detailed above have not been and will not be reimbursed by any health insurance or reimbursement plan. I am not applying these expenses toward any federal or state income tax deduction or credit. I assume all responsibility for any taxes or penalties arising out of any disallowed deductions.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

_____ _____

Your Signature Date