

Select one:

Original submission

Resubmission



Health Reimbursement Account (HRA) Claim Form

How to complete the form

- Complete sections **A**, **B** and **C**.
- Attach an Explanation of Benefits (EOB) from the insurance carrier, prescription drug co-pay receipts, or a printout of drugs purchased from your pharmacy provider. The document(s) attached needs to include all of the following:
 - 1) Provider name and address
 - 2) Patient name
 - 3) Itemized charges
 - 4) Date of service
 - 5) Type of service
- Canceled checks, non-itemized receipts and balance due bills are **not acceptable** proof of expenses.
- For questions, call the phone number on the back of your ID card, or contact us online at www.healthscopebenefits.com.

A. Employee information

HealthSCOPE Benefits Employee ID Number (from front of ID card) _____	Employer _____
Employee name (Last, First) _____	Phone number or email _____-_____-_____
Address _____ City _____ State _____ ZIP _____	
Patient name (Last, First) _____ Patient date of birth <u> </u> / <u> </u> / <u> </u> MM DD YYYY	

B. Expenses

Start date of service	End date of service	Provider of service (doctor or pharmacy) Include name and address	Type of service	Amount of reimbursement requested
<u> </u> / <u> </u> / <u> </u> MM DD YYYY	<u> </u> / <u> </u> / <u> </u> MM DD YYYY	_____	Prescription Other	\$ _____
<u> </u> / <u> </u> / <u> </u> MM DD YYYY	<u> </u> / <u> </u> / <u> </u> MM DD YYYY	_____	Prescription Other	\$ _____
<u> </u> / <u> </u> / <u> </u> MM DD YYYY	<u> </u> / <u> </u> / <u> </u> MM DD YYYY	_____	Prescription Other	\$ _____
<u> </u> / <u> </u> / <u> </u> MM DD YYYY	<u> </u> / <u> </u> / <u> </u> MM DD YYYY	_____	Prescription Other	\$ _____
Total reimbursement request				\$ _____

C. Certification

I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:

- They were incurred for services or supplies by me or my eligible dependents under the plan.
- They were for services or supplies furnished on or after the effective date of my health reimbursement account.
- I have not been reimbursed for these expenses in any other way.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my health reimbursement account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

Employee signature (required) _____ Date (required) / /
MM DD YYYY

(Continued)

You can send the **completed first page only** by:

MAIL: **HealthSCOPE**, P.O. Box 30962, Salt Lake City, UT 84130-0962

FAX: **855-405-2189**

For Inquires: **www.healthscopebenefits.com** or call the phone number on the back of your ID card

Reimbursement instructions – please review

Eligible services and documentation requirements:

The expense must be a health-related expense incurred by you or one of your eligible dependents. This means amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure of the body. Expenses must be medically necessary and not for cosmetic purposes or general good health.

Supporting documentation must accompany this request form. Please adhere to the following do's and do not's:

Do	Do not
<ul style="list-style-type: none">• Send an itemized bill or receipts showing the dates of service, type of service, provider name, patient's name and amount of service with this form.• Send a copy of an Explanation of Benefits (EOB) from any insurance plan under which the expense is covered. When applicable your insurance claim must be finalized prior to submitting for HRA reimbursement.• Complete the total requested amount.• Send the documentation on white paper. Colored paper is not legible when scanned.• Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.• Make a copy of the form and documentation for your personal records.	<ul style="list-style-type: none">• Do not submit canceled checks or credit card receipts alone. These are not adequate documentation without supporting itemization.• Do not submit balance forward statements.• Do not submit bank statements.• Do not highlight names, prices, or dates on receipts. They are not legible when scanned.• Do not submit handwritten receipts for prescriptions or over-the-counter items.• Do not submit pre-treatment estimates or estimated insurance statements.• Do not submit date expense was paid.

Actual dates of service must be indicated on the claim form. The IRS allows reimbursement for services when the care is provided, which may not be the actual date that the patient pays or is formally billed for the charges.

EOB Email notification allows you to receive an e-mail notifying you once your claim has been processed and an EOB is available to view online. Signing up is easy and convenient at **www.healthscopebenefits.com**.

Letter of Medical Necessity (LOMN) is additional documentation needed when an item normally not considered eligible is needed to treat a specific medical condition. This letter would need to be completed by your provider stating which service or item is needed and for what type of condition. A LOMN is required annually. If you are not sure if a service or item will be covered please review the listing of eligible/ineligible items available online, refer to your plan document or please contact HealthSCOPE Benefits customer service.

Examples of items needing a LOMN are 1) vitamins/supplement 2) massage therapy 3) weight loss programs.

Limitations on reimbursement of over-the-counter supplies (Stockpiling) will be followed if your plan allows reimbursement of over-the-counter supplies. You will only be reimbursed for a reasonable quantity of an eligible over-the-counter medical care expense as determined by the plan administrator under the Plan (i.e., 10 boxes of adhesive bandages in one month would not be reasonable). Please refer to your Plan Document to verify if OTC are eligible.

Automatic reimbursement may be a feature your employer has chosen. This feature allows any patient liability amounts to be automatically reimbursed from your health reimbursement account once your HealthSCOPE Benefits medical claims are processed when you have a HealthSCOPE Benefits medical plan. Please contact HealthSCOPE Benefits customer service to verify if this feature is allowed and if you are eligible to participate.

Please note: If you have automatic reimbursement for the benefits listed above, please do not submit a manual claim.

Health Savings Account (HSA) owners only: I understand that (1) I may not submit any expenses that would apply toward the deductible on my high-deductible health plan (HDHP).