Claim Form

YOU COULD BE GETTING YOUR REIMBURSEMENT FASTER! File your claim online via the employee portal (BRIWEB)or via the BRIMOBILE app, if allowed by your plan.

Employee Name

Member ID *(set by your employer. Typically an employee ID or SSN.)*

Employer

Check here if address has changed and provide new information below.

Street or PO Box

City | State | ZIP

What are you requesting a reimbursement for? *(One claim type per form.)*

Health Accounts (FSA, HRA) | Dependent Care (Child care expenses) | Commuter Expenses | Other / Specialty Accounts

Provider & Type of Service *(i.e. RX, Co-pay, Dental, Child care, Parking)*	Start and End Dates *(MM/DD/YYYY)*	Person Receiving Service *(First and Last Name)*	Amount	Office Use
			$.	
			$.	
			$.	
			$.	
			$.	

CERTIFICATION AND AUTHORIZATION: By submitting the claim form, I certify that: (1) The information on this form is accurate and complete. (2) I am requesting reimbursement for eligible expenses provided to myself or qualifying individuals while a participant in the plan. (3) I have already received these products and services and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. If I am covered under more than one healthcare account, reimbursement will be made according to the payment order determined by those plans and as stated in my plan documentation. (4) Use of this service indicates my acceptance of the terms and conditions associated with my plan and available through my secure login at BenefitResource.com.

WHAT YOU NEED TO KNOW WHEN SUBMITTING YOUR CLAIM:

- Provide an itemized receipt or an EOB if required by your plan. Credit card receipts are generally not accepted.
- Check your plan highlights to determine what expenses are eligible, required documentation for claim submissions, and when claims must be submitted by.
- Additional forms you might need (Available on BenefitResource.com/forms)
  - *Dependent Care Receipt*: Submit this fill-in form with a completed claim form when requesting reimbursement from your Dependent Care FSA if you do not have an itemized receipt, invoice, bill, or statement from the care provider.
  - *Mileage Expense Certification Form*: Submit this fill-in form with a completed claim form when requesting reimbursement for transportation expenses related to essential medical care (16 cents/mile for 2021; Rate subject to IRS changes), parking, and tolls from your FSA or HRA.
  - *Certification of Medical Necessity*: Submit this fill-in form with a completed claim form once per year to receive reimbursement for dual-purpose items from your FSA or HRA.
- Visit BenefitResource.com/ClaimsHelp for further assistance in filling out this form.

SUBMIT CLAIM BY MAIL: Benefit Resource, LLC | PO BOX 642 | Willow Grove, PA 19090

© 2024 Benefit Resource, LLC. | All rights reserved | Updated 1/26/2024 | (800) 473 - 9595 | ParticipantServices@BenefitResource.com | BenefitResource.com

Benefit Resource and BRI are tradenames of Benefit Resource, LLC . Benefit Resource, LLC is an affiliate of Inspira Financial Health, Inc. and Inspira Financial, LLC. Benefit Resource, LLC does not provide legal, tax or financial advice. Please contact a professional for advice on eligibility, tax treatment and other restrictions. Inspira and Inspira Financial are trademarks of Inspira Financial Trust, LLC.

City of Haverhill – HRA Reimbursement Information

If you are enrolled in a health insurance plan through the City of Haverhill and can answer **YES** to any of the questions below, you *may* be eligible for reimbursement!

1	Are you a **retiree**, age **65** or over, and **not Medicare eligible?** If you answered **YES to all 3**, you are eligible for **full reimbursement** of your deductible. (Excludes Fallon Health plans.)
2	Have you or a covered spouse or dependent **ever been charged $1,500** for an **inpatient copay?** If you answered **YES**, you may be eligible for reimbursement of up to **$800**.
3	Have you or a family member stayed **over night at Holy Family Hospital** in Haverhill or Methuen ***and*** charged an inpatient copay? If you answered **YES**, you are eligible for reimbursement of the copay of up to **$50** for Medicare retirees and **$275** for all others.
4	Do you think you have exceeded **$2,000 in out of pocket costs** for yourself or a family member (includes copays, deductibles, prescriptions, but not premiums)? If you answered **YES**, you may be eligible for reimbursement of costs that exceeded **$2,000**. Please contact Human Resources for review. (Exceptions may apply.)
5	Did you **pay your full deductible** for your individual or family plan? If you answered **YES**, you are eligible for reimbursement of up to **$100** for a family plan and up to **$200** for an individual plan. (Excludes Fallon Health plans.)