Health Reimbursement Account (HRA) Claim Form

Step 1: Claim Information

Today's Date: _____/_____/_____ Number of pages: _____ Plan year beginning for: 20____

☐ New Claim ☐ Resubmission of claim ☐ Response to claim denial

Step 2: Participant Information

*=Required Fields

City of Haverhill

*Employer Name (Do not abbreviate) Department

*Participant Name (First, MI, Last) *Social Security Number

*Participant Mailing Address ☐ Check here if change of address Email Address (If provided, all notifications will be sent via email)

*City *State *Zip

Medical Plan Enrollment and Information

☐ Active ☐ Non-Medicare Retiree ☐ Non-Medicare Retiree (over 65) ☐ Surviving Spouse

Medical Plan Name: _____

Step 3: Reimbursement Request

*Employee, Spouse or Dependent Name	*Amount Requested	*Date of Service	*Type of Service	Expense Type (See reverse)

Total Amount Requested: $_____

Please note the following requirements for claims submission:

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do **NOT** consider cancelled checks as valid documentation.
- Please submit your Explanation of Benefits (EOB) for reimbursement
- All reimbursements will be made payable to the employee.

Step 4: Authorization

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my account be reduced by the amount requested.

SIGNATURE OF PARTICIPANT_____ **DATE** _____

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

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.)