HRA Claim Form

Today's Date: ____/____/____ # of pages: _____ Plan Year: 20 _____

❑ New Claim ❑ Response to Claim Denial

Employee Name:	Employer Name/Division Name:	
Employee Address: ☐ Please check if change of address; you must also change with your HR department.		
Social Security Number or Member ID Number:	Work Phone: ( )	Home Phone: ( )

**Minimum check reimbursement is $25; minimum reimbursement for direct deposit is .50*

❑ **Health Reimbursement Arrangement (HRA)** **Total Amount Requested:** _____

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	**E**mployee, **S**pouse or **D**ependent	Amount Requested	Type of Service (R_x, co-pay, dental expense, etc.)	Service Provider Number/ R_x Number
1.				
2.				
3.				
4.				
5.				

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's Signature: _____ Date: _____/_____/_____

Revised 4/9/2015

HRA Claim Form

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 14202-3204

P&A Group Customer Service Information

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

WEBSITE: www.padmin.com
TOLL-FREE: (800) 688-2611