HealthPlans
A HARVARD PILGRIM COMPANY

# Claim Form – Health Reimbursement Arrangement (HRA)

*Use this form to submit for reimbursement of eligible expenses.*

| | | | |
|---|---|---|---|
| Employer/Company Name | Department/Division | Health Plans Member ID# | |
| Employee Last Name | Employee First Name (Subscriber) | M.I. | DOB (MM / DD / YYYY) |
| Street Address | City | State | ZIP Code |
| Email Address | ( ) Home Phone Number | ( ) Work / Mobile Phone Number | |

## Instructions

Please attach copies of insurance Explanation of Benefits (EOB) or itemized bill/invoice, which includes the following information:

- the date(s) of service
- the name and address of the provider who provided the service
- the amount of the charges

| Date of Service | Name of Service Provider | Net Amount |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | **Total from Page 2** | $ 0.00 |
| | **Claim Total** | $ **0.00** |

## Please Read Carefully

The undersigned Plan Participant (Subscriber) certifies that all expenses claimed herein were incurred during a period of active coverage; that all applicable insurance or other health benefits have been exhausted; and that the subscriber will not deduct or take these reimbursements as tax credit(s). The undersigned understands that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information contained herein, and that if an expense claimed herein is not an eligible expense under the plan, the undersigned may be liable for the payment of all related taxes (including federal, state, or city income tax) arising out of any disallowed expense.

I certify that all items claimed herein comply with the Health Reimbursement Arrangement program, and said items have not and will not be covered by any other plan or program of any employer, or other party, and will not be reimbursed through a rebate program.

Employee Signature ***(required)*** Date

**Print and submit this form to:**

**Health Plans, Inc.**
Attn: Flexible Spending Dept.
PO Box 5199
Westborough, MA 01581

**or fax to: 508-329-4815**

***Please retain a copy of this form and all related documentation for your records.***

*Questions? Please call **800-343-7674, ext. 8416**, or submit your question online at **www.healthplansinc.com**, and click on **Contact Us**.*

*rev. 5/12/2011*

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Subscriber Name _____ Health Plans Member ID# _____

| Date of Service | Name of Service Provider | Net Amount |
|---|---|---|
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**Page 2 Total** $ 0.00

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