HRA Claim Form **Employer:**_____ **Plan Year:**_____

Use this form to file **unreimbursed manual claims**. If the plan includes a benefits debit card, do NOT use this form to verify purchases made on that card. Uncashed reimbursements are forfeited after 180 days. **Call (865) 769-2800 or e-mail Flex@BenefitsAssist.net with any questions.**

WHERE TO FILE MANUAL CLAIMS

E-mail (up to 10MB) – Flex@BenefitsAssist.net
Mail – P.O. Box 31823, Knoxville, TN 37930-1823
Fax – (888) 588-3650 (cover page is NOT required)

DATE OF SERVICE AND FILING DEADLINE

-Date of service must be between your plan year enrollment date and the plan year end date
-For **terminated participants**, date of service must be between your plan year enrollment date and your termination date
-Claims filing deadline is the earlier of 90 days after termination or 90 days after plan year end

WHEN CLAIMS ARE PROCESSED

-Normally processed every other Monday.
-Claims received by the previous Thursday's close of business included in bi-weekly Monday process.

WHAT TO INCLUDE WHEN FILING

-This claim form
-Copies of insurance carrier's Explanation of Benefits or provider's invoice forms showing: Employee or dependent name
Provider name
Date of service
Description of service
Charge
-To speed up processing, label your attached documents with a claim# (1, 2, 3, A, B, C, etc.) and attach them in the order they are listed below
-Unacceptable documentation: Cancelled checks, credit/debit card receipts, non-itemized cash register receipts, previous balance statements, balance forward statements, claims for future service
-Please keep copies of all submitted materials for your records

ONLINE ACCESS

You can check your balance by logging into https://www.benefitspayment system.com and clicking 'Participant Login' in the middle part of the page. E-mail Flex@BenefitsAssist.net for login instructions.

INFO

Check box only if below address is new

Employee Name (Last, First, MI) Mail Address: Number and Street City, State, Zip

Last 4 digits of Social Security Number Daytime Phone

Unreimbursed manual **HRA expenses**

Claim#	Person Receiving Service	Relation (Employee, Spouse, Child)	Type of Service (Med, Den, Vis, OTC, Prescription)	Provider/ Merchant	Dates(s) of Service	Amount Requested
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$
						$

TOTAL AMOUNT TO BE REIMBURSED: **$**_____

I certify that: 1) I agree to the terms of the HRA, including any tax consequences, as described in the Plan document of the Health Reimbursement Arrangement Plan; 2) Either I, my Spouse, or my Dependent have incurred these expenses and the expenses have not previously been reimbursed under the HRA or any other plan or source, and I will not seek reimbursement for them under the Medical Insurance Plan or any other health plan or tax deduction/credit; 3) The expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and are not toiletries.

Signature_____ Date _____

Reimbursable benefits under the HRA

This HRA provides for the reimbursement, subject to the maximums and other conditions of the HRA plan, only for medical expenses incurred after enrollment that are covered under the employer's medical plan.

- **Employee Only Coverage** - See plan for details.
- **Family Coverage** - See plan for details.