[your organization]

HRA Reimbursement Request Form

Employer Name	Employee Social Security Number
	- -

Employee Name	Employee Daytime Phone Number

Employee Address

City	State	Zip

HEALTH CARE EXPENSES

Patient Name	Relationship to Employee	Type of Expense	Start Date of Service	End Date of Service	Total Charge	Amount to Be Reimbursed

Note: Include proof of expenses and explanation of why they are not covered by the insurance plan.

PROOF OF EXPENSES MUST INCLUDE:

For Medical	**For Rx**
Patient's name	Patient's name
Name and address of provider	Amount charged
Amount charged	Date the prescription was filled
Type of service	**One of these:** Name of medication **OR** the National Drug Code (NDC) number **OR** the word "co-payment" printed on receipt
Date of service	

Note: Provide an itemized receipt for each amount requested, or your request will be denied. Please don't send credit card receipts, cashed checks or copies of checks. They are not acceptable receipts for reimbursement.

Signature of Service Provider	Date

I hereby request payment from my health reimbursement arrangement for the expenses listed above. I certify that I have not been reimbursed for these expenses from any other health plan. I understand that any expenses reimbursed may not be used to claim any federal income tax deduction or credit. I hereby authorize a deduction from my flexible spending account.

Signature of Employee	Date