HRA - REIMBURSEMENT REQUEST FORM

Employee Name: _____ **SS#:** _____ **Company Name:** _____

Employee Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employee Home Phone #: _____ **Employee Work Phone #:** _____

INSTRUCTIONS:

- Please complete this information for eligible expenses incurred by you or your eligible dependents.
- Attach supporting documentation for each expense including information listed on the reverse of this form.
- Canceled checks, credit card statements or cash register receipts cannot be accepted.
- **FAX (or mail) this signed and dated form with supporting documentation to NPA. Please keep a copy.**

	EXPENSE #1	EXPENSE #2	EXPENSE #3	EXPENSE #4	EXPENSE #5
Date(s) Service Provided (Not Date Paid)	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____
Relationship to Participant	☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child
Type of Service (Copay, Dental, RX, Vision, etc.)					
Total Expense	$	$	$	$	$
Amount of Reimbursement Requested	$	$	$	$	$

INSURANCE PREMIUM	Period of Coverage _____ to _____	☐ Self ☐ Spouse ☐ Child	☐ Medical ☐ Dental ☐ COBRA ☐ Vision ☐ Long Term Care	To document expense, submit one of the following: ☐ Payroll stub showing premiums paid with after-tax dollars, or ☐ Invoice directly from Insurance Co. for premiums billed to participant	Amount Requested $

Total HRA Amount Requested: $

I understand that I can only be reimbursed an amount up to the total funds currently in my HRA account and any remainder will be reimbursed, as funds become available. I certify all expenses listed above have been incurred and have not been reimbursed and are not reimbursable under any other health plan coverage or a Flexible Spending Account (FSA), or my FSA has been exhausted, or I do not have an FSA. I certify that the premium expenses above do not represent premium contributions deducted as part of a Section 125 Cafeteria Plan. I understand that I am required to submit along with this form, a copy of an itemized bill, statement or receipt from the provider or other third-party stating the date, amount and description of medical services. I represent the individual for whom claim is filed qualifies as a dependent for federal income tax purposes and is consistent with IRS guidelines. I further understand that these expenses can not be deducted on my federal, state or local income tax returns.

_____ Employee Signature

_____ Date

_____ E-mail Address

NATIONAL PLAN ADMINISTRATORS, INC.
P.O. BOX 161630
AUSTIN, TX 78716

FAX: (512) 275-9396 or (800) 982-8140
PHONE: (512) 327-6481 or (800) 880-2776
www.natlplan.com

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HRA QUALIFYING MEDICAL EXPENSES

The Health Reimbursement Arrangement Plan Document contains the rules governing what expenses are or are not reimbursable. Below are some examples to give you a general idea. Please contact National Plan Administrators, Inc. (800) 880-2776, if you have any questions about whether a particular expense is reimbursable or not.

Examples of expenses for which you may be able to receive reimbursement include:

- Deductibles and co-payments for medical, prescription drugs, vision and/or dental expenses
- Over the counter drugs and items that are used to alleviate or treat a personal injury or sickness
- Eye exams, eyeglasses, contact lenses and other vision expenses
- Hearing exams, hearing aids and batteries
- Individual psychotherapy; chiropractic expenses
- Orthodontia monthly and down payments per orthodontic contract
- Acupuncture with letter of medical necessity
- After-tax Insurance Premiums that are not a part of a Section 125 Cafeteria Plan

Examples of expenses for which you <u>cannot</u> be reimbursed include:

- Over the counter items or vitamins, herbal remedies or supplements (even if prescribed) that are for general good health
- Cosmetic surgery or other similar procedures or drug, which is directed at improving the patient's appearance and does not meaningfully, promote the proper function of the body to prevent or treat illness or disease
- Teeth bleaching; health club dues; custodial care
- Weight reduction or management related expenses unless submitted with letter of medical necessity from physician

HRA CLAIM SUBMISSION PROCEDURES

Claim forms are available online at *www.natlplan.com/forms.htm*. In addition, you will receive a new claim form each time you are issued a reimbursement check or notice of direct deposit.

According to the Internal Revenue Code, the Health Reimbursement Arrangement may reimburse an expense if the participant provides

- A written statement, receipt or bill from an independent third party stating the expense(s) has been incurred;
- The amount of such expense(s);
- A signed statement that the expense has not been reimbursed or is not reimbursable under any other health plan coverage or a Flexible Spending Account.

<u>Procedures for submitting claims that will help to ensure prompt and efficient processing:</u>

1. For ALL medical expenses, itemized billings must be submitted to NPA for reimbursement with the following information:
    - Date of service,
    - Description of services provided,
    - Prescription drug name (only for a prescription),
    - Patient name,
    - Provider name and address,
    - Total amount of payment for which you are seeking reimbursement,
    - An Explanation of Benefits (EOB) from an insurance company, if applicable, must also be submitted.
    - Over the counter drugs and items must have a receipt that contains the date purchased, name and cost of item. If the receipt does not provide a name, then the box top or box side must be submitted that contains the name and cost of item that corresponds to the receipt.
    - Insurance premium reimbursement requests must also submit either a payroll stub showing the premium was paid with after-tax dollars or an invoice directly from the Insurance Company showing premiums are billed directly to the participant or the participant's dependent.

2. When filing orthodontic claims <u>for the first time</u>, NPA must have *a copy of the Orthodontic Contract* including the down/initial payment, schedule of payments, when banding will occur and the duration of the treatment. Thereafter, simply submit a claim form with receipts and indicate that it is an orthodontic treatment expense. Claims can only be reimbursed for payments made according to the orthodontic contract payment schedule.

3. **Please be sure to retain copies for your files of all items submitted to NPA for reimbursement.**