PlusPoint

Health Reimbursement Arrangement

HRA Claim Form

Remit To:
Plus Point Services
307 oak street
hood river, or 97031
PHONE: 541.386.1696
FAX: 541.386.2280
EMAIL: Admin@pluspoint-tpa.com

Employee Information					
Employer Name:		Daytime Phone:			
Employee Name:		Employee ID:			
Employee Address:					
City:		State:		Zip:	
Email Address:					

PLEASE NOTE: Claims that are not listed on this from cannot be processed. You must complete each field below for each claim you are seeking reimbursement for and attach supporting documentation. If your HRA is a deductible reimbursement plan please make sure to provide a carrier EOB (Explanation of Benefits).

HRA CLAIMS – for unreimbursed medical expenses (Attach supporting documentation)

Supporting documentation for unreimbursed medical expenses must include all of the following:

--- Provider's Name ---- Patients Name
--- Service Description ---- Amount Billed
--- Date of Service
An EOB is required for deductible HRA reimbursements

Date of Service	Apply to Plan Year: Current/Previous?	Name of care recipient and relationship to employee	Name of Medical Provider	General Medical Expense Description	Amount
				Total Amount Requested:	

Employee Confirmation

By signing this from I certify that: all expenses listed above are for reimbursement, have been incurred by myself or an eligible family member, have not been reimbursed and are not reimbursable from another source including a future or previous plan year. I certify that all expenses were incurred during the reimbursable plan year period or grace period covered by the Health Reimbursement Arrangement. I certify that attached to this form are bills, statements, or other qualifying evidences of expense as required. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns.

Employee Signature: _____ Date: _____