FIRST BENEFIT ADMINISTRATORS

HRA CLAIM FORM

Please attach documentation with this form

Employer Name	
Employee Name (First & Last Name)	
Social Security Number	
Daytime Phone Number ☐ *check if phone number has changed*	
Address: ☐ *check if address has changed*	Street: City: State: Zip:
Email	

Please include Explanation of Benefits (EOB) in the order you have listed below. Complete the form with date(s) of service, description, claim total, sign and date below. The EOB **must include** the following: date of service, type of service, type of expense (i.e. eye exam), and the amount applied to the deductible and name of the service provider.

Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

NOTE: CANCELLED CHECKS OR CREDIT CARD RECEIPTS/STATEMENTS ARE NOT VALID FORMS OF DOCUMENTATION.

	Date(s) of Service	Description	Dollar Amount
1			$
2			$
3			$
4			$
5			$
6			$
7			$
		Claim Total:	$

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and that neither myself nor dependent are enrolled in a HSA bank account. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HRA to be reduced by the amount requested.

Signature:	**Date:**

What to submit for reimbursement:

- HRA claim form completed, signed & dated and
- The Explanation of Benefits (EOB) from the medical Insurance company

How to submit: (email, mail or fax)

- **Email**: info@firstbenefitadmin.com
- **Mail:** First Benefit Administrators 13080 Belcher Rd S. #A Largo, FL 33773
- **Fax:** 727-532-9602

Questions: Call 727-530-4144 or 1-800-571-4144

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