Health Reimbursement Arrangement (HRA)
Reimbursement Voucher

EMPLOYER NAME

YOUR NAME S.S. NUMBER (Last 4 Digits)

YOUR ADDRESS CITY STATE ZIP

☐ PLEASE CHECK THIS BOX IF THERE IS A CHANGE OF ADDRESS.

Home Phone # ______________________ Work Phone # ______________________

SUBMITTING YOUR CLAIM FOR REIMBURSEMENT:

- Fill out your name, last 4 digits of your SS# and your address.
- List the **nature or description of service**, **date of service** and **amount of the services** submitting for reimbursement.
- Attach **copies** of third-party invoices to substantiate your claim. This must include explanation of benefits (EOB) from your insurance carrier. ALL documentation must show the date of service, patient name, description of service, name of provider and amount of service. *NO cancelled checks or credit card receipts or statement can be accepted.*
- **Sign and date your voucher**. Your claim will not be processed without your signature.

Health Expenses

Receipts must include description of service, date of service, and dollar amount.

Nature of Service *	Date(s)	Amount Claimed
1		$
2		$
3		$
4		$
5		$
6		$
7		$
8		$

*An Explanation of Benefit (EOB) **must** be submitted if your HRA pays for a portion of your health insurance deductible.

TOTAL from HRA $

READ CAREFULLY AND SIGN

This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations for HRA's, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for re-crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

X

SIGNATURE *Date*

Mail or fax completed vouchers to:

The Preferred Group
P.O. Box 15136
Albany, NY 12212-5136
(518) 641-0321 (800) 573-7474
Fax: (518) 641-0325
www.thepreferredgroup.com