HRA REIMBURSEMENT REQUEST

(PLEASE NOTE – This form is NOT for Medical Expense Accounts. Please use the Medical Expense Reimbursement Request form)

(USE THIS FORM TO SUBMIT CLAIMS BY FAX OR MAIL)
(To send scanned claims go to: www.allegianceflexadvantage.com ***)***

FAX: 406-523-3149 or **TOLL FREE FAX:** 877-424-3539

PHONE: 406-721-2222 or **TOLL FREE PHONE:** 877-424-3570
Please visit www.allegianceflexadvantage.com for additional forms.

Comment Box

Return FAX # _____

Return Phone # _____

PAGES: _____including this cover sheet

Attention To:

Please use black or dark blue ink. Do not use highlighter, red ink or gel pens. DO NOT include day care or flexible spending account expenses on this form.

Company:(Print) _____
(Required)

Employee Name:(Print) _____ Participant ID: _____
(Required) **(Last Four Numbers Required)**

List eligible expenses for you and your family that you have not already claimed. Only list the amount of the expense you have to pay **after insurance** pays its share.

Services Listed	Service Date	Covered By Insurance?	Out-of Pocket Expense
_____	___/___/___	Y☐ N☐	$ _____
_____	___/___/___	Y☐ N☐	$ _____

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY AS DOCUMENTATION. FOR EXPENSES NOT COVERED BY INSURANCE, SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.

I certify that these statements are true and that the claimed expenses cover only myself, my qualifying dependents, and/or spouse. I further understand that expenses reimbursed by an HRA may not be reimbursed by a flexible spending account or claimed on my individual tax return at the end of the year.

Employee Signature: _____ Date: _____

☐ Check here if your address has changed. Please list to the right.

New Address:

_____

_____