

# HRA CLAIM FORM



Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# of pages: \_\_\_\_\_

Plan Year: 20 \_\_\_\_\_

New Claim

Response to Claim Denial

Employee Name: Employer Name/Division Name:		Employer Name/Division Name:	
Employee Address: <input type="checkbox"/> Please check if change of address; you must also change with your HR department.			
Social Security Number or Member ID Number:	Work Phone: (    )	Home Phone: (    )	

*\*Minimum check reimbursement is \$25; minimum reimbursement for direct deposit is .50*

**Health Reimbursement Arrangement (HRA)**      **Total Amount Requested:** \_\_\_\_\_

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Rx, co-pay, dental expense, etc.)	Service Provider Number/ Rx Number
1.				
2.				
3.				
4.				
5.				

*I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been reimbursed under any other health plan; furthermore, I will not seek reimbursement of the expenses under any other health plan.*

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# HRA CLAIM FORM



## Claim Submission Guidelines

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- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do not consider cancelled checks as valid documentation.
- Previous balances are not acceptable.
- All reimbursements will be made payable to the employee.

Send completed claims via fax or mail to P&A Group.

FAX: Toll-free (877) 855-7105 or (716) 855-7105

MAIL: Flex Department

17 Court Street, Suite 500

Buffalo, NY 14202-3204

## P&A Group Customer Service Information

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Customer service representatives are available Monday - Friday, 8:30 AM - 10:00 PM ET.

WEBSITE: [www.padmin.com](http://www.padmin.com)

TOLL-FREE: (800) 688-2611

## Electronic Claim Submission

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Upload and submit your claims directly to the P&A website from your mobile device or computer. Log into your P&A account for more information.

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