HRA 105(h) Claim Form

Date: ______ Number of Pages: ______ Plan Year: ______

☐ New Claim ☐ Response to Denial

Employer Name/Division Name: ______

Employee Name: ______

Address: ☐ Please check if change of address ______

Email: ______

SSN: ______ Home Phone: ______ Work Phone: ______

☐ Health Reimbursement Account (HRA) Total Amount Requested: ______

*Please enclose the bill from your insurance carrier showing date of service, services rendered, provider of service, and the amount paid.

	Date of Service	Employee, Spouse, or Dependent	Amount Requested	Type of Service (Rx, co-pay, dental, 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.

______ Date: ______

Signed By

Revised 2/13/2012

HRA 105(h) Claim Form | Guidelines

P&A Group

Claim Submission Guidelines

* 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 the 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

Customer service representatives are available Monday - Friday from 8:30 a.m. - 8:00 p.m. EST.
Call toll-free: (800) 688-2611

Website: www.padmin.com

NEW! Electronic Claim Submission Feature Now Available

Upload and submit your claims directly to the P&A Website. Log into your account, click on the "Member Tools" tab and select the "Upload a Claim" option.