HealthComp®
Third Party Administrators

HRA CLAIM FORM

Employee Information

Employer's Name		
Employee's Name (Last, First, MI)		Social Security Number
Employee's Address *If change of address, check box→* ☐		City, State, Zip Code
Home Phone Number	Work Phone Number	Email Address

Claim Information

Date of Service		Name of Provider	Recipient of Services		Claim Amount
			Name	Relationship	
1.					$
2.					$
3.					$
4.					$
5.					$

Grand Total: $

HRA Expense Reimbursement Guidelines:

- ✓ Acceptable documents to attach to this reimbursement form are: (1) professional bills or receipts that include the provider of service, type of service, date of service, charge for the service; (2) Insurance Company Explanation of Benefits;
- ✓ Unacceptable documents include: (1) Cancelled checks; (2) credit card receipts; (3) bill or receipt that only show a balance forward, previous balance or a payment due.

The undersigned participant in the HRA certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) while the undersigned was covered under the Employer's HRA Plan and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee's signature:_______________________________ Date:____________________

Where to Submit:

Mail: HealthComp Administrators
Attn: Flex/HRA Dept.
P.O. Box 45018
Fresno, CA 93718

Email: flexbenefits@healthcomp.com

Web site: www.healthcomp.com

Contact Info: Phone: (559) 499-2450; or (800) 442-7247
Fax: (559) 499-2045

Always keep a copy of your claims submitted for your records

FOR OFFICE USE ONLY	
CLAIM #	
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