



CLAIM FORM Claim Form Filing & Documentation Instruction

Company Name: _____ New Claim Additional Information requested
 Employee Name: _____ Last four numbers of Social Security #: _____
 E-mail: _____ Phone: _____

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| <p>(1) Please sign claim form, include your email address and provide complete documentation for requested information.</p> <p>(2) Attach an Explanation of Benefits (E.O.B.) or itemized bill from the provider showing the provider name, expense description, date of service, amount paid and , if applicable, amount covered by insurance. Credit card receipts or cancelled checks are not acceptable. HRA reimbursement requires an E.O.B.</p> | <p>(3) For Dependent Care reimbursement, please include the dates of care (not payment dates) and provider name, address and tax id number. Provider's signature required only if receipt is not provided.</p> <p>(4) Submit pharmacy RX stub with date filled, prescription name/Rx Number, patient name, and amount charged.</p> <p>(5) Cash register receipts are acceptable for over the counter expenses.</p> |
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Please note: If you are submitting Debit card verification receipts, please use the mySourceCard Substantiation Form available on our website

Health Care Expenses

| Date of Service | Account Type (FSA, HRA, Dental / Vision Reimbursement) | Provider Name | Type of Service or Prescription (Rx) Name/ Number | Participants or Family Member Name | Reimbursement Request Amount |
|-----------------|--------------------------------------------------------|---------------|---------------------------------------------------|------------------------------------|------------------------------|
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| TOTAL | | | | | |

Dependent Care Expenses

| Name of Eligible Dependent(s) | Date(s) of Care | | Name, Address, & Taxpayer Identification No. (Or Social Security No.) of Service Provider | Amount Charged |
|-------------------------------------|-----------------|-----|-------------------------------------------------------------------------------------------|----------------|
| | From | To | | |
| | / / | / / | | |
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| | / / | / / | | |
| | / / | / / | | |
| Total Dependent Care Expense | | | | |

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|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Provider's Signature _____ | |
| Employee Certification | <p>I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents. These expenses are not, and will not, be payable by any other plan, will not be reimbursed or discounted from any other source and will not be deducted on my federal, state or local income tax returns.</p> <p>_____ Employee Signature (REQUIRED) _____ Date</p> |

MAIL Claim Form and Receipts to: Human Resource Administrators, Inc., PO Box 8, Center Valley, PA 18034

FAX Claim Form and Receipts to: (610) 282-4216

FOR MORE CLAIM FORMS OR TO CHECK YOUR ACCOUNT BALANCE, VISIT WWW.HRADMINISTRATORS.COM