HRAdministrators

View your account balance at www.hradministrators.com

CLAIM FORM

Claim Form Filing & Documentation Instruction

Company Name: _____ ☐ New Claim ☐ Additional Information requested

Employee Name: _____ Social Security #: _____

E-mail: _____ Phone: _____

(1) Please sign claim form, include your email address and provide complete documentation for requested information. (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 & CAT reimbursement requires an E.O.B.	(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. (4) Submit pharmacy RX stub with date filled, prescription name/Rx Number, patient name, and amount charged. (5) Cash register receipts are acceptable for over the counter expenses.

Please note: If you are submitting Debit card verification receipts, please use the mySourceCard Substantiation Form available on our website

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

Health Care Expenses

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		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
			Total Dependent Care Expense	

Provider s Signature

Employee Certification	I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other benefit plan nor will they be deducted on my federal, state or local income tax returns. _____ _____ **Employee Signature (REQUIRED)** **Date**

MAIL Claim Form and Receipts to: Human Resource Administrators, Inc., 1541 Alta Drive, Suite 306 Whitehall PA 18052

FAX Claim Form and Receipts to: (610) 774-9910

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