



Houghton Lake Community Schools Health Reimbursement Arrangement Request Form

MAIL CLAIMS TO: Professional Benefits Services or Fax (616) 285-0701
HRA Department
2959 Lucerne SE, Suite 205 Email claims to:
Grand Rapids, MI 49546 hra@professionalbenefits.net

For questions please call: (616) 285-2480 or (800) 732-3412

Employee Instructions:

- 1 Reimbursement form must be complete and clear. **Failure to answer any questions or provide proper documentation may delay payment.**
- 2 All receipts **must** have a name, date of service, type of service, a provider, and the amount of the charge.
- 3 A copy of Explanation of Benefits (EOB) is required for reimbursement of medical services.
- 4 A copy of the prescription is required for reimbursement of pharmacy expenses.
- 5 Attach paid receipts. **Cancelled/Copies checks will not be accepted.**

Employer\Place of employment _____ Department _____

Employee Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Change of Address

Employee Number _____ or Social Security Number (Optional) _____

| Name of person receiving service | Relationship to insured | Service date | Amount of reimbursement requested |
|----------------------------------|-------------------------|--------------|-----------------------------------|
| 1. _____ | _____ | _____ | \$ _____ |
| 2. _____ | _____ | _____ | \$ _____ |
| 3. _____ | _____ | _____ | \$ _____ |
| 4. _____ | _____ | _____ | \$ _____ |
| 5. _____ | _____ | _____ | \$ _____ |
| 6. _____ | _____ | _____ | \$ _____ |
| 7. _____ | _____ | _____ | \$ _____ |

TOTAL REIMBURSEMENT REQUESTED FROM HRA \$ _____

REMEMBER IF YOUR COMPANY HAS A FLEXIBLE SPENDING ACCOUNT AND YOU PARTICIPATE IN THE PROGRAM THE HRA PLAN WILL PAY FIRST.

To the best of my knowledge and belief, this Reimbursement Request Form is complete and true. I certify that my family member or myself has received the services described above on the date indicated, that the expenses qualify as a valid medical service under the Plan. If the expense is for my spouse or dependent, I certify that the person's receipt(s) meets the definition of dependent\spouse in the plan. I certify that I have not been reimbursed previously for these expenses under the Health Reimbursement Plan or any other health plan. I understand that these expenses may not be used to claim any federal income tax deduction or credit.

Employee Signature

Date