HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM
(Please Print Legibly)

EMPLOYEE INFORMATION			
NAME:	SSN #:	DAY TIME PHONE #:	
☐ CHECK HERE IF NEW ADDRESS	EMPLOYER NAME:		
ADDRESS:	EMAIL ADDRESS:		
CITY:		STATE:	ZIP:

REIMBURSABLE EXPENSES (Attach documentation)

DATE INCURRED	PROVIDER OF SERVICE	PERSON FOR WHOM SERVICE PROVIDED	REIMBURSEMENT AMOUNT REQUESTED
			$
			$
			$
			$
			$
			$
			$
		TOTAL	$

CERTIFICATION

I certify the following is true:

1. The expenses listed above were incurred by me and/or my eligible dependents and qualify for reimbursement.
2. The appropriate bills, receipts, Explanation of Benefits statements or documentation are attached.

Member Signature **(REQUIRED)**:	Date:

Any person who knowingly and with intent to defraud or deceive any health care plan, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

FAX TO: (877) 240-0135
OR MAIL TO
HEALTHSCOPE BENEFITS, INC.
P.O BOX 3627
LITTLE ROCK, AR 72203

FOR MORE INFORMATION ABOUT YOUR ACCOUNT, PLEASE VISIT OUR WEBSITE:
www.healthscopebenefits.com

CUSTOMER CARE
1-888-763-8232