



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

EMPLOYEE INFORMATION

NAME:		SSN #:	DAY TIME PHONE #:
<input type="checkbox"/> 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:

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

Member Signature (REQUIRED):	Date:
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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
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**

