



Health Reimbursement Account Claim Form

Employee's Name : _____

Company Name: _____

ID Number (see member ID card): _ _ _ _ _

Employee's Daytime Phone Number: (_____) _____

Patient's Name (if different from employee): _____

Total Amount Submitted for Reimbursement: \$ _____

NOTE: Please attach the Explanation of Benefits (EOBs) for services received. For prescription drugs, if they are reimbursable from your HRA, please attach a drug receipt.

Employee Certification

I authorize my Health Reimbursement Account (HRA) to be reduced by the amount of expenses listed above. The expenses incurred by myself or my eligible dependents are not reimbursable from any other source. I understand that any expenses reimbursed cannot be claimed as credits or deductions on my income tax return. I further certify that I have read and understand the information outlined on the back of this form. The information on this form is true and correct to the best of my knowledge.

Employee's Signature _____ Date _____

When to File this HRA Claim Form

Please refer to the election confirmation letter we mailed to your home for an explanation of when you are required to complete this claim form. Or, you may visit your company's Human Resources department.



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

Health Reimbursement Account Claim Form

How to File an HRA Claim

1. Once you receive an EOB, you may request reimbursement from your HRA by completing this **HRA Claim Form**.
2. Attach the EOB to the **HRA Claim Form** for eligible services received.
3. For your records, keep copies of all claim forms and documentation you submit.
4. Return the completed **HRA Claim Form** and supporting documents via mail or fax.

How to Contact Us

Mailing Address: **HRA Claims Unit
P.O. Box 100237
Columbia, SC 29202**

Phone: **Call the toll-free number located on your member ID card**

Fax: **(803) 870-8028**

Web site: **www.MyInsuranceManager.com/FL**