

Health Reimbursement Account (HRA) Claim Form

Step 1: Claim Information

Today's Date: ____/____/____

Number of pages: _____

Plan year beginning for: 20____

☐ New Claim

☐ Resubmission of claim

☐ Response to claim denial

Step 2: Participant Information

*=Required Fields

City of Haverhill

*Employer Name (Do not abbreviate)

Department

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address ☐ Check here if change of address

Email Address (If provided, all notifications will be sent via email)

*City

*State

*Zip

Medical Plan Enrollment and Information

☐ Active

☐ Non-Medicare Retiree

☐ Non-Medicare Retiree (over 65)

☐ Surviving Spouse

Medical Plan Name: _____

Step 3: Reimbursement Request

*Employee, Spouse or Dependent Name	*Amount Requested	*Date of Service	*Type of Service	Expense Type (See reverse)

Total Amount Requested: \$ _____

Please note the following requirements for claims submission:

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do **NOT** consider cancelled checks as valid documentation.
- Please submit your Explanation of Benefits (EOB) for reimbursement
- All reimbursements will be made payable to the employee.

Step 4: Authorization

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my account be reduced by the amount requested.

SIGNATURE OF PARTICIPANT _____ DATE _____

Please fax this completed form to Pro-Flex Administrators, LLC: 716-929-2013 or toll free 1-855-214-8987
or mail to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221

Visit our website to access account information at www.proflextpa.com

City of Haverhill – HRA Reimbursement Information

If you are enrolled in a health insurance plan through the City of Haverhill and can answer **YES** to any of the questions below, you *may* be eligible for reimbursement!

	<p>Are you a retiree, age 65 or over, and not Medicare eligible?</p> <p>If you answered YES to all 3, you are eligible for full reimbursement of your deductible. (Excludes Fallon Health plans.)</p>
	<p>Have you or a covered spouse or dependent ever been charged \$1,500 for an inpatient copay?</p> <p>If you answered YES, you may be eligible for reimbursement of up to \$800.</p>
	<p>Have you or a family member stayed over night at Holy Family Hospital in Haverhill or Methuen <u>and</u> charged an inpatient copay?</p> <p>If you answered YES, you are eligible for reimbursement of the copay of up to \$50 for Medicare retirees and \$275 for all others.</p>
	<p>Do you think you have exceeded \$2,000 in out of pocket costs for yourself or a family member (includes copays, deductibles, prescriptions, but not premiums)?</p> <p>If you answered YES, you may be eligible for reimbursement of costs that exceeded \$2,000. Please contact Human Resources for review. (Exceptions may apply.)</p>
	<p>Did you pay your full deductible for your individual or family plan?</p> <p>If you answered YES, you are eligible for reimbursement of up to \$100 for a family plan and up to \$200 for an individual plan. (Excludes Fallon Health plans.)</p>