Health Reimbursement Arrangement (HRA) Claim Form

Effective January 1, 2011, for HRA plans with spousal and/or dependent coverage a separate claim form is required for each individual for whom a claim is filed.

Company/Employer Name			
Employee Information			
First name / Middle initial	Last name	Social Security Number – –	Phone number ( )
Home mailing address	City	State	ZIP Code
E-mail address (W*ill only be used to contact you about your account.)*			

Please answer the following questions about the Claimant (the person incurring the expense that gives rise to this claim).

Claimant Information		
First name / Middle initial	Last name	Relationship of Claimant to Employee Self Spouse Dependent
Medicare Reporting Questions Regarding the Claimant*		
1. Is Claimant between the ages of 45 and 64? YES NO	2. Regardless of age, is Claimant currently entitled to Medicare? YES NO	3. Regardless of age, does Claimant receive kidney dialysis or has Claimant ever received a kidney transplant? YES NO
If you answered "YES" to ANY of Questions 1, 2,or 3, complete Questions 4 through 7.		
4. Claimant's Date of Birth (mm/dd/yyyy) / /	5. Claimant's Gender Male Female	6. Claimant's Social Security # – –
7. If the Claimant has a Medicare Health Insurance Claim Number (HICN) please provide it here. (Write "N/A" if not applicable.)		

Attach Explanation of Benefits (EOB) forms specific to the expenses incurred by the above Claimant.

EOB forms may be obtained by contacting your health insurance provider.

Please read this section carefully before signing: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was an eligible employee covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses **have not and will not be reimbursed under any other health plan coverage**. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for repayment to the Plan any or all amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature (*Required*) **Date**

Submit your claim: (Always keep a copy of your paperwork for your records.)
Mail: HRA Claims, Savers Administrative Services, 635 W. Fourth Street, Suite 201, Winston-Salem, NC 27101-2740
Fax: 336-759-3999, attention HRA Claims.
Email: flex@saversadmin.com – scan and send claim form and EOBs as attachments

*Provisions under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) add mandatory reporting requirements for Medicare beneficiaries who are covered under an HRA Plan. Reporting is required on any covered employee, their spouse, or their dependent if any of these individuals may be eligible for or are already covered by Medicare. Effective January 1, 2011, to meet new federal Medicare reporting requirements, a separate claim form is required for each individual ("Claimant") for whom an HRA claim is filed.

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