



HRA Reimbursement Request

Date _____

FAX - # Pages _____

Please follow the steps below to thoroughly and accurately complete this form.

STEP 1: Company Name _____ Day Phone _____

STEP 2: Employee Name _____ SSN _____

STEP 3: HRA CLAIMS			
Date of Service (MM/DD/YYYY)	Name of Provider	Description of Service	Claim Amount
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			Total \$

Payout Schedule – Claims Reimbursement Checks are distributed twice a month.

If claims are received by 5 p.m. on the 5th/20th of the month, reimbursement checks/reports will be sent to the employer by the 15th/End of the Month.

STEP 4: EMPLOYEE CERTIFICATION
<p>I certify that the expenses for which I am seeking reimbursement from the HRA have been incurred by me, or by an individual who qualifies as my spouse or my dependent for federal income tax purposes. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account (HSA). I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.</p> <p>Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.</p> <p>Sign Here ► Signature of Employee _____ Date _____</p>

Submit a Reimbursement Request in four easy steps....

1. Provide acceptable proof of paid expenses. We request that you send COPIES of your proof of expenses since they will not be returned to you. For tax purposes, you should retain the original proof of expense, such as a copy of the explanation of benefits sent to you by Aetna stating the portion of the claim paid **OR** a copy of the bill from the provider stating the services and date performed and method of payment used.
2. Write the total amount for reimbursement which can be found in Step 3.
3. Sign and date the form.
3. Attach all copies pertaining to your claim to this form and send the request via mail or fax to **1-847-332-0335**.

Mailing Address:

Aetna
10275 W. Higgins Road, Suite 500
Rosemont, IL 60018
Phone: 1-866-472-0897
Fax: 1-847-332-0335
E-mail: aetnasupport@flexiblebenefit.com