HEALTHCARE REIMBURSEMENT ACCOUNT CLAIM FORM

HRA Reimbursement Request

This Claim Form is to be used only for reimbursement for your Hospital, Diagnostic, Therapy & other Deductible services. It may not be used for reimbursement of any other medical expenses, such as Office Visit co-payments or Prescription Drug co-payments. PLEASE INCLUDE YOUR BLUE CROSS OF NORTHEASTERN PENNSYLANIA HEALTH PLAN EXPLAINATION OF BENEFITS (EOB) SHOWING YOUR DEDUCTIBLE AMOUNTS.)

INSTRUCTIONS:

- Use this form to Submit Claims.
- Include a copy of your Health Plan's Explanation of Benefits (EOB), showing your deductible amount.
- Submit claim to: DeHEY McANDREW LLC, P.O. Box 447, Scranton, PA 18501, attn: HRA Claim.

(Please Print Clearly)

_____
Blue Cross Member ID Number

_____ _____
Employee Name Employer

___ ___ ___ - ___ ___ - ___ ___ ___ ___ (_____) _____-_____ (_____) _____-_____
Social Security Number Home Phone Work Phone

_____ _____ _____ _____
Street Address City State Zip Code

_____ Check One: [ ] Employee [ ] Dependent
Patient's Name Relationship:_____

[ ] Reimburse Employee [ ] Send Payment Directly to Provider ^

^Provider & Address:_____

_____

DATES OF SERVICE(S):	PROVIDER NAME:	DEDUCTIBLE:	SERVICE TYPE*:

*You can find your "Service Type" on your Explanation of Benefit (EOB) from Blue Cross under "Member Responsibility."

I certify that these statements are true and the claimed expenses cover only me, my tax dependents, and/or spouse. I further understand that expenses reimbursed by an HRA may not be reimbursed by a Flexible Spending Account or claimed on my individual tax return.

_____ _____
Employee Signature Date