



First Benefit Administrators

Please attach documentation to the back of this form.

HRA CLAIM FORM

Email Address: _____
Employee _____
Employer Name _____
SSN: _____

COMPLETE FOR CHANGE OF ADDRESS ONLY
New Address: _____
City _____
State, Zip _____
Phone: _____

THIS FORM SHOULD BE COPIED FOR FUTURE USE.

Please attach the EOB in the order you have it listed below and fill in with dates of service, description, and claim total, then sign and date below and mail or fax to FBA.

NOTE: CANCELLED CHECKS OR CREDIT CARD RECEIPTS/STATEMENTS ARE NOT VALID FORMS OF DOCUMENTATION.

DATE(S) OF SERVICE	DESCRIPTION	DOLLAR AMOUNT
1.		\$ _____
2.		\$ _____
3.		\$ _____
4.		\$ _____
5.		\$ _____
6.		\$ _____
7.		\$ _____
CLAIM TOTAL		\$ _____

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HRA to be reduced by the amount requested.

Signature: _____ Date: _____

REMINDERS

- ⇒ Provide an EOB from United Health Care for all eligible Coinsurance expenses submitted. Deductibles and Co-pays are not eligible expenses.
- ⇒ Sign & Date the Reimbursement Form
- ⇒ Multiple expenses may be included on one form. If more space is needed.

Mail or Fax Completed Forms to: **FIRST BENEFIT ADMINISTRATORS, INC**

13080 Belcher Road South, Suite A Largo FL 33773

Phone: 727.530.4144 ♦ Fax: 727.535.3977

www.firstbenefitadmin.com