## HEALTH REIMBURSEMENT ACCOUNT (HRA) PLAN CLAIM FORM PLUMBERS & STEAMFITTERS LOCAL 21

PART 1			
Members Last Name	First Name	Middle	Social Security
Street or P.O. Box			Phone Number
City		State	Zip Code
Local #			

PART 2					
Patient Name	Date of Service	Type of Service	Provider Name	Claim Amount	
			AMOUNT REQUEST	AMOUNT REQUESTED:	

## ALL REQUESTS FOR REIMBURSEMENT MUST INCLUDE THE FOLLOWING INFORMATION:

- -Name of patient for which the medical expenses have been incurred.
- -The type of service and the date the expense was incurred.
- -The amount of the requested reimbursement.
- -Copies of itemized bills, invoices, or other statements from an independent third party showing that the medical care expense(s) have been incurred and the amount of such expense along with a paid receipt.

IN ORDER TO OBTAIN REIMBURSEMENT FROM THE HRA, YOU MUST COMPLETE THIS CLAIM AND SUBMIT IT ALONG WITH ANY SUPPORTING DOCUMENTATION BY THE <u>SECOND FRIDAY OF EVERY MONTH</u> WITH A <u>SELF</u> ADDRESSED STAMPED ENVELOPE. CHECKS ARE PROCESSED ON THE THIRD WEDNESDAY OF EACH MONTH.

NOTE: FOR COBRA PAYMENTS; PLEASE IDENTIFY THE MONTH (S) FOR WHICH YOU ARE SEEKING BENEFIT COVERAGE

-OVER-

**CREDIT ON ACCT:** 

READ CAREFULLY: I CERTIFY THAT EITHER I AND/CEXPENSES FOR WHICH REIMBURSEMENT IS CLAIMED IN HAVE NOT BEEN REIMBURSED AND THAT THE EXPENSIONAL SOURCE.	FROM THE HRA PLAN AND I FURTHER DELCLARE THAT I		
SIGNATURE OF PARTICIPANT:	DATE:		
MAIL TO: Plumbers & Steamfitters Local 21 — HRA 1024 McKinley Street Peekskill, NY 10566 Attn: Linda 914 737-7220 Fxt. 121	NOTE: FOR COBRA PAYMENTS, PLEASE IDENTIFY THE MONTH (S) FOR WHICH YOU ARE SEEKING BENEFIT COVERAGE.		

SEND ALL DOCUMENTATION WITH A
SELF ADDRESSED STAMPED ENVELOPE

Patient Name	Date of Service	Type of Service	Provider Name	Claim Amount