

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

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

PART 2				
<i>Patient Name</i>	<i>Date of Service</i>	<i>Type of Service</i>	<i>Provider Name</i>	<i>Claim Amount</i>
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.
- A minimum of \$100 of claims should be accumulated before a claim for reimbursement is submitted.

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

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