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 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 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.

-OVER-

READ CAREFULLY: I CERTIFY THAT EITHER I AND/OR MY ELIGIBLE DEPENDENTS HAVE INCURRED THE EXPENSES FOR WHICH REIMBURSEMENT IS CLAIMED FROM THE HRA PLAN AND I FURTHER DELCLARE THAT I HAVE NOT BEEN REIMBURSED AND THAT THE EXPENSES ARE NOT REIMBURSABLE THROUGH ANY OTHER SOURCE.

SIGNATURE OF PARTICIPANT: _____ *DATE:* _____

MAIL TO: *Plumbers & Steamfitters* *Local 21 – HRA* *1024 McKinley Street* *Peekskill, NY 10566* *Attn: Linda* *914 737-7220 Ext. 121* *SEND ALL DOCUMENTATION WITH A SELF ADDRESSED STAMPED ENVELOPE*	***OFFICIAL USE ONLY*** *DATE:* _____ *AMOUNT:* _____ *APPROVED:* _____ *DISAPPROVED:* _____ *NOTES:* _____

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

HRA FORM CAN BE OBTAINED ONLINE AT WWW.LOCAL21UNION.COM CLICK MEMBERSHIP NEWS, HRA FORM