Health Reimbursement Arrangement (HRA) Claim Reimbursement Request Form

Company Information (PLEASE PRINT)	
Company Name	Division (if applicable)

Participant Information (PLEASE PRINT)			
Last Name		Primary Phone	
First Name		Secondary Phone	
SSN (or Alternate Employee ID)	Date of Birth (mm/dd/yyyy)	Email Address (For Account Notifications)	
Street Address (Check if New Address ☐)			Apt Num
City		State	Zip
If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:			
Name	**Relationship to Participant**		**Date of Birth**

REIMBURSEMENT REQUEST (PLEASE PRINT)

Please indicate your eligible expenses below. **DO NOT include expenses reimbursed by any other source**.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation as specified by your plan. Documentation must include dates of service, description of service, provider's name and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

Date Range of Services	From through	**TOTAL Reimbursement Request**
Description (Please list a brief description below of services – ie: Dr Visit, Prescription, Copay, etc…)		**$**_______________
		(REQUIRED)

CLAIM CERTIFICATION

To the best of my knowledge and belief, my statements on this form are complete and true. I certify that my family member or I have received the services described above on the dates indicated and that the expenses qualify as valid medical expenses under the plan. I certify that these expenses have not been reimbursed under any other plan, nor will I seek reimbursement for any of these expenses elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **Any person who, with intent to defraud or knowing they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or healthcare fraud under state and/or federal law.**

Participant Signature (required)	Date

SEND THIS FORM TO CHARD SNYDER

Please submit this form to Chard Snyder by one of the methods listed to the right

☑ **Fax:** 888.887.9961 ***(Please DO NOT include a Fax Cover Page)***

☑ **Mail to:** P.O. Box 2905, Fargo, ND 58108-2905

Health Reimbursement Arrangement (HRA)
Claim Reimbursement Instructions

1. **Complete all company and participant information** on the front page (please print/type). NOTE: Please include your e-mail address if you want to receive an automatic e-mail notification when a claim is entered into our system and when a reimbursement is approved for you to receive payment

2. **Attach supporting documentation**. A copy of the documentation required by your plan must accompany the claim form in order for your request to be considered for reimbursement. *Do not highlight any part of your documentation.* Be sure to keep your original receipts, bills, etc. for your records. All receipts are destroyed daily. All requests must include the following information to be eligible for reimbursement
   - ☑ Original date of service (not the date of payment)
   - ☑ Description of the service performed (refer to list of eligible expenses to identify valid services)
   - ☑ Amount charged to you (do not include amounts reimbursed by another source)

3. **Health Reimbursement Arrangement (HRA):** Complete all required information *(ie: Total Reimbursement Request Amount)* and attach proof of expenses as described above. *Important: Most plans require a copy of your EOB to process an HRA claim – please see your plan information for details of claim requirements*

4. **You MUST sign and date** the *Claim Certification* section on the front of this page.

5. **Fax or Mail** this form and supporting documentation directly to Chard Snyder:
   - ☑ **Fax to:** 888.887.9961 (***Please DO NOT include a Fax Cover Page***)
   - ☑ **Mail to:** P.O. Box 2905, Fargo, ND 58108-2905

6. **If you have questions** please contact us…
   - ☑ Call Participant Services: 800.284.8412
   - ☑ Visit our Website: www.benefit-info.com/csn
   - ☑ Email your questions to: csaskpenny@wexinc.com

7. **Important** Reminders:

   All requests are saved as electronic images. To ensure your claim is processed as quickly as possible, and avoid delays:
   - ☑ Do NOT use a Fax Cover Page when faxing
   - ☑ Do NOT Highlight any part of your receipts, bills, etc.
   - ☑ Only send copies of receipts, bills, etc. (Keep your originals)
   - ☑ Payments are issued after receipt and processing, subject to claim approval
   - ☑ Any items for which you are reimbursed cannot be claimed again as deductions or credits on your individual tax return at the end of the tax year
   - ☑ You may only be reimbursed for eligible expenses incurred during the current plan year

     Note: Orthodontia expenses are reimbursed as designated by the provider
   - ☑ Payment will be made to you. Payments cannot be made to a provider or another person
   - ☑ If you request reimbursement by check and your approved payment is less than $25, we will wait to send reimbursement until we receive additional claims that make your total reimbursement amount at least $25. If we don't receive any additional claims, we will send your reimbursement at the end of the plan's runout period. There is no minimum amount required for reimbursement by direct deposit.

Sign up for direct deposit in your online account today! It's faster, more convenient, and more secure.