PATIENT ADVOCATES
THE WAY HEALTHCARE SHOULD BE

HEALTH CARE REIMBURSEMENT ARRANGEMENT
REIMBURSEMENT REQUEST FORM
(HRA)

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ARRANGEMENTS WILL BE MADE PAYABLE TO THE EMPLOYEE.

Name	ID#
Address (Street)	Employer
Address (City,State,Zip)	Group Number

HEALTH CARE REIMBURSEMENT ARRANGEMENT

- List reimbursable expense and attach Explanation of Benefits and/or an itemized bill.
- If an expense is covered in part by a health plan, the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. If no health plan benefit applies write "none" in the Plan Payment column.
- Attach a second form if you need additional space.

Expense For			Dates of Service		Total Bill	Plan Payment	Reimbursement
First Name	Age	Relationship	From	To	**(Attach Copy)**	**(Attach EOB)**	Amount Due
					$	$	$
					$	$	$
					$	$	$
					$	$	$
					$	$	$
					$	$	$
					$	$	$
					$	$	$
					$	$	$
			TOTALS				**$**

1. I certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes and penalties arising out of any disallowed deductions.

SIGNATURE:_____ DATE:

MAIL TO: **Patient Advocates, LLC * P.O. BOX 1959 * GRAY, ME 04039 * FAX: (207) 657-7744**