HRA Reimbursement Claim Form

Please review MBA's Claim Submission Guidelines (on the back of this form) to ensure you include the proper documentation for this claim. MBA will not be able to process your claim without the adequate documentation.

Keep a copy of all original documentation.

Employee Information

EMPLOYER			
Employee Last Name	First Name	Social Security Number (SSN)	
Mailing Address	City, State and Zip	Is this a new address? ☐	
Employee Email Address		Phone	

Health Related Expenses

Date of Service (MM/DD/YY)	Patient's Name	Relationship	Type of Service	Provider Name	Amount Requested
				Total	

Unreimbursed Health-Related Expenses	This plan is for your out of pocket medical expenses. Medical expenses are the costs of diagnosis, cure, mitigation, treatment or prevention of disease, and the costs for treatments affecting any part or function of the body. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. MEDICAL EXPENSES must be from a Group Health Plan. Expenses from individual coverage are not eligible for reimbursement under an HRA Plan. Eligible Expenses may also include dental and vision expenses. (IRS Publication 502 – www.irs.gov)

I certify that the above information is correct and hereby authorize release of payment through my reimbursement account(s). I further certify that these expenses have not been and will not be reimbursed from this plan, any other health plan coverage, or any other plan. I alone am responsible for the sufficiency and accuracy of all information relating to this claim and that, unless an expense under the Plan, I may be liable for payment of all related taxes, including federal, state, or city income tax on amounts paid from the plan that relate to such expenses.

Employee Signature	Date

Please submit your claim form and appropriate supporting documentation:

Fax: (208) 887-1313
Scan/Email: HRA@mba-admin.com
Mail: MBA Administrators
PO Box 370 | Meridian ID 83680

Claim Submission Guidelines and Tips

Required For ALL Claims

Each HRA Reimbursement claim submitted, whether faxed, mailed or emailed MUST include:

- ✓ **Completed** MBA Reimbursement Claim Form **Signed** by the Employee
- ✓ **AND – one of the following listed below:**

✓ Required for Medical Reimbursement Claims:

Medical, Dental or Vision Claims ***WITH*** *Insurance and/or Secondary Coverage*	Medical, Dental or Vision Claims ***WITHOUT*** *Insurance Coverage*

• Include an Explanation of Benefits (EOB) from the insurance carrier
• The EOB should indicate the out-of-pocket expense
	• Include an itemized bill or receipt from the provider that includes the following:
	  • Patient's Name
	  • Type of Service
	  • Provider's Name and Address
	  • Dollar Amount
	  • Date(s) of Service

✓ Required for Pharmacy Claims:

Prescription Drug Claims *Filled at a Pharmacy or Mail Order*	Over-the-Counter (OTC) Drug Claims

• Include an itemized bill or receipt from the provider that includes the following:
  • Patient's Name
  • Patient Costs / Carrier Payment
  • Prescription Number *(Drug name not necessary)*
  • Pharmacy's Name and Address
  • Dollar Amount
  • Date(s) when Prescription was dispensed
	• Written Prescription by Physician prescribing the OTC drug
	• Cash Register Receipt
	  • Facility's Name and Address
	  • Dollar Amount with an indication of an FSA eligible expense and/or name of OTC drug
	  • Patient Costs
	  • Date(s) of Service

General Notes:

- Reimbursement is not a guarantee this payment is tax-free.
- Expenses must be for you or eligible individuals under this Plan.