

Instructions for Requesting Reimbursements from your HRA



Instructions

1. Complete the Employee Information Section.
2. Complete the Health Care Reimbursement section. If all entries will not fit on one form, complete and submit an additional form(s) as necessary.
3. **Attach supporting documentation** as described below.
 - ❑ **Explanation of Benefits Form (EOB):**

This is the form you receive each time you or a health care provider submits claims for payment to your medical, dental, or other health care plan. The EOB will show the amount of the expenses paid or denied by the plan and the amount you must pay. For all health care expense that are partially covered by your (or your spouse's) medical, dental, or other health care plans, you must attach an EOB.
 - ❑ **All Other Health Care Expenses:**

For expenses not covered at all by your (or your spouse's) medical, dental, or other health care plans, reimbursement requests will not be processed without acceptable evidence of your expenses. Acceptable evidence includes itemized statements that contain the following information:

 - a. Actual date(s) expense was incurred*
 - b. Name of person for whom the service/supply was provided
 - c. Person or organization providing the service/supply
 - d. Description of service or supply
 - e. Cost (*Note: finance charges are not a reimbursable expense.*)
4. **Sign** and date the form.
5. **Mail or fax the completed, signed form and attachments** to the address or fax number on the front of the form. An incomplete form, missing signature or missing attachments may result in delayed processing or claim denial.
6. If you have any questions regarding your reimbursement account or claims, please call (866) 853-2698.

**Only expenses incurred during the current year are eligible for reimbursement.*

HRA Request for Reimbursement



Please fax completed form to the number below, or mail to:
 Wells Fargo Health Benefit Services, P.O. Box 45600, Salt Lake City, UT 84145-0600

Contact Information				
Company Name			Employee Social Security #	
Last Name		First Name		M.I.
Address Change <input type="checkbox"/>	Street Address	City	State	Zip
E-Mail Address		Home Phone # (area code)	Work Phone # (area code & ext.)	

*** Wells Fargo Health Benefit Services policy requires that this form be filled out completely (see form instructions). Incomplete and undocumented claims will not be processed. ***

Health Care Reimbursement				
Date Expense Incurred Month / Day / Year ____/____/____	Patient Name	Name of Service Provider	Expense Description	Amount \$
Date Expense Incurred Month / Day / Year ____/____/____	Patient Name	Name of Service Provider	Expense Description	Amount \$
Date Expense Incurred Month / Day / Year ____/____/____	Patient Name	Name of Service Provider	Expense Description	Amount \$
Date Expense Incurred Month / Day / Year ____/____/____	Patient Name	Name of Service Provider	Expense Description	Amount \$
<input type="checkbox"/> Additional Claim Forms are attached.				Total \$

I request reimbursement for the expenses listed above. I am including receipts or other appropriate third party proof that I incurred these expenses during the plan year and during a period while the undersigned was covered under this plan. I have not been reimbursed for these expenses under our insurance plan or under any other source.

I understand that I cannot claim these same expenses on my personal tax return since I have already received a tax advantage on these amounts via the Section 125 Plan.

Employee Signature	Date Submitted
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Web site: www.wfhbs.com/bcbsmichigan
 Phone: (866) 853-2698
 Fax: (888) 824-3868