Health Reimbursement Account (HRA) Claim Form

How to file a claim:

Online: Log into your benefits portal or use the MyChoice Mobile App to submit your claim electronically.

Via email, fax or mail: Fill out your form electronically and submit via email, fax, or mail.

- **Email**: claims@mychoiceaccounts.com
- **Mail**: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax**: 855-883-8542

Instructions for filling out this form:

Complete each section in full.
If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

Ⓐ EXPENSE TYPE *(indicate the type of expense that is being claimed for reimbursement)*

Ⓑ START AND END DATE OF CLAIM

Ⓒ AMOUNT OF CLAIM SUBMITTED

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES): 3231921003

COMPANY NAME: Acme Company

RETIREE LAST NAME: Smith

HOME ZIP CODE: 90012

EMAIL: SSmith@Acme.org

DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES): 9191243109

SECTION 2: YOUR HEALTH CARE EXPENSES

Ⓐ EXPENSE TYPE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION ☐ OTHER _____

Ⓑ CLAIM START DATE (MM/DD/YY): 020120

CLAIM END DATE (MM/DD/YY): 022820

Ⓒ AMOUNT: $ 323.19

To ensure your claim is submitted successfully:

Be sure to attach a copy of the Explanation of Benefits, or itemized invoice(s), including:

a. The date the expense was incurred (not the date paid and no future dates)
b. The name of service provider or carrier name
c. A description of the service and/or expense
d. The amount of the expense

Please Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.

mychoice™ Accounts

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SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

COMPANY NAME

LAST NAME

HOME ZIP CODE

EMAIL

DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR HEALTH CARE EXPENSES

EXPENSE TYPE

☐ MEDICAL ☐ PRESCRIPTION
☐ DENTAL ☐ PREMIUM
☐ VISION

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$ ____.__

Carrier Name ____________________

EXPENSE TYPE

☐ MEDICAL ☐ PRESCRIPTION
☐ DENTAL ☐ PREMIUM
☐ VISION

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$ ____.__

Carrier Name ____________________

EXPENSE TYPE

☐ MEDICAL ☐ PRESCRIPTION
☐ DENTAL ☐ PREMIUM
☐ VISION

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$ ____.__

Carrier Name ____________________

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free.
- Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.

I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.