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

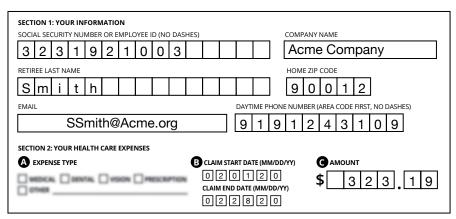
• **Fax**: 855-883-8542

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.

- A EXPENSE TYPE (indicate the type of expense that is being claimed for reimbursement)
- **B** START AND END DATE OF CLAIM
- **©** AMOUNT OF CLAIM SUBMITTED



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.





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Use only CAPITAL LETTERS, completely fill in and use only blue or black ink.



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SECTION 1: YOUR INFORMATION SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES) COMPANY NAME LAST NAME HOME ZIP CODE DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES) **EMAIL SECTION 2: YOUR HEALTH CARE EXPENSES EXPENSE TYPE** SERVICE START DATE (MM/DD/YY) **AMOUNT MEDICAL PRESCRIPTION DENTAL PREMIUM** SERVICE END DATE (MM/DD/YY) VISION Carrier Name **EXPENSE TYPE** SERVICE START DATE (MM/DD/YY) **AMOUNT MEDICAL PRESCRIPTION PREMIUM DENTAL** SERVICE END DATE (MM/DD/YY) **VISION** Carrier Name **EXPENSE TYPE** SERVICE START DATE (MM/DD/YY) **AMOUNT MEDICAL PRESCRIPTION DENTAL PREMIUM** SERVICE END DATE (MM/DD/YY) **VISION**

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.

Carrier Name

- 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.