P.O. Box 928
Findlay, OH 45839
651-695-2500
800-486-7664
Fax: 419-423-5834
www.ebsobenefits.com

HRA REIMBURSEMENT CLAIM FORM

Please Print

Employer____

Your Name____

ID # and/or Birthdate____

☐ My address has changed. My new address is____

____

Medical Expenses

Medical expenses covered under an insurance plan must be submitted to the insurance carrier first.

In order to process your HRA claim, EBSO must receive proper documentation. To process your expense(s), EBS0 must receive a copy of your medical explanation of benefits. **Balance due statements and canceled checks are not acceptable.**

This entire form must be completed in order for EBSO to process your claim. Complete the rest of the form and send to: EBSO at the address shown above.

Date of Service	Person Receiving Service (Self, Spouse, Dependent)	Type of Expense (Check One)		Total Expenses	Amount Paid By Insurance	Amount To Be Paid From Your HRA Account
		Medical	Drugs			
			Totals	$		$

I hereby certify that the information shown above is true and correct, and that neither I, my spouse, nor any of my eligible dependents have or will receive reimbursement for any of the expenses listed above from any other source, and furthermore, that I have not, and will not, claim any of these expenses as a deduction on, or in calculating a credit for, my/my spouse's income taxes. In addition, I certify that the "Person Receiving Service" listed above is eligible to be covered under the Plan.

Signature____ Date____________________

Please send completed and signed copy to customerservice@ebsobenefits.com or to the fax number or mailing address at the top of this form. Questions, contact EBSO Customer Service at 651-695-2500 or 800-486-7664.

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