HRA Reimbursement Request Form

Section 1 This section must be completed fully for all claims. **(PLEASE PRINT)**

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

ADDRESS: _____

☐ **Check if this is a NEW address** EMPLOYEE DAY TIME PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Section 2 This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation **MUST** be attached. We want to promptly process your claims. Failure to complete all appropriate sections will cause claims to be denied. Please keep a copy of this form for your records.

PATIENT NAME: _____

TOTAL REIMBURSEMENT REQUESTED: $ _____

ALL CHECKS WILL BE MADE PAYABLE TO THE INSURED UNLESS A PROVIDER NAME AND ADDRESS IS PROVIDED BELOW *(Please use additional forms for multiple providers)*

DOCTOR OR HOSPITAL NAME: _____

BILLING ADDRESS: _____

_____

_____

_____

Section 3 Employee's Signature is required to process this claim.

AUTHORIZATION: I authorize any medical professional, hospital, other medical facility or provider to disclose to Envision Healthcare, Inc. information concerning care, treatment or billing for any treatment I obtained at that facility. This authorization shall expire on the date in which my employer terminates coverage with Envision Healthcare, Inc. I also understand that I may revoke this authorization at any time, but that such revocation will have no effect on any actions taken by Envision Healthcare, Inc. prior to receipt of revocation. I understand that information disclosed pursuant to the authorization may be re-disclosed and no longer protected by federal privacy laws. I authorize Envision Healthcare, Inc. to transmit the information contained electronically.

NOTE: For medical expenses, you must attach a written statement from an independent third party stating that a) the medical expense has been incurred; b) the amount of the expense; and c) that the medical expense has not been reimbursed or is not reimbursable under any other health plan coverage. Cancelled checks are no acceptable.

SIGNATURE: _____ **DATE**: _____

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