Please complete when faxing your claim:

Date: _____

# of Pages: _____

Return Fax #: _____

Please print clearly. Thank you!

Insight
Benefit Administrators

Health Reimbursement Account (HRA) Program

_____Pay Member _____Pay Provider

Claim Form

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where required.

Employee Name _____ Employee Social Security # _____

Employer _____ Daytime Telephone _____ Check here if this is a change of address: ☐

Home Address _____

City _____ State _____ ZIP Code _____

Health Reimbursement Account

Service Date	Name of Service Provider	Name of Family Member for whom Reimbursement is Requested & Relationship	Date of Birth	Service Description	Amount Requested for Reimbursement
					$
					$
					$
					$

WILL ANY OF THE ABOVE EXPENSES BE COVERED OR REIMBURSED FROM ANY OTHER SOURCE (e.g. Blue Cross, an HMO or another Employer's Insurance Plan)? ☐ **NO** ☐ **YES** If yes, you must attach copies of the other plan's explanation of benefits form.

Participant's Signature _____ **Date** _____

Submit Reimbursement requests to: **Insight Benefit Administrators LLC**
Fax: (616) 588-7915
Email: RA_TPA@insightba.net

Phone: (877) 827-1414

For a complete up-to-date list of Eligible Products & Services please reference the FSA Store's Eligibility List

https://fsastore.com/FSA-Eligibility-List.aspx?utm_source=Insight+Benefit+Administrators+LLC&utm_medium=TPA+OFF+OE&utm_campaign=TPA+Partner&a_aid=4fce4ff301434