

Please complete when faxing your claim:

Date: _____

of Pages: _____

Return Fax #: _____



Please print clearly. Thank you!

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** Phone: (877) 827-1414
Fax: (616) 588-7915
Email: RA_TPA@insightba.net

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