HRA

HEALTH REIMBURSEMENT ARRANGEMENT

REIMBURSEMENT REQUEST FORM

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* from your insurance carrier and an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim. Be sure to sign and date this form. You may photocopy this form.

Employer's Name:	**Last 4 Digits of Employee's SS #:**
Employee's Name:	**E-Mail Address:**
Employee's Address:	**Daytime Telephone #:**
Employee's City, State, Zip:	

UNREIMBURSED MEDICAL EXPENSES

Patient Name	Relationship	Age	Date of Service	Type of Service (Medical, Dental, etc.)	Amount Requested
1.					
2.					
3.					
4.					
5.					
				Total	

I, the undersigned, hereby certify that the above listed expenses are for myself or a Federal Tax-qualified dependent and have not been previously reimbursed from my Health Reimbursement Arrangement, nor are reimbursable from any other source. I hereby authorize Stanley Benefits to obtain necessary information from all physicians, hospitals, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

I also authorize Stanley Benefits to use electronic mail to communicate with me regarding my claims, reimbursements or requests for receipts.

Employee's Signature **Date**

Stanley Benefits ✦ P. O. Box 8249 ✦ Greensboro, NC 27419-0249
Toll-Free Telephone: (877) SBS-FLEX [877-727-3539]
Toll-Free Fax: (877) 4FAX247 [877-432-9247]