

HRA REIMBURSEMENT REQUEST

Employee Name: _____ ID #: _____

Address: _____

Check here if new address _____ Phone: _____

Expense Reimbursement Information

Date of Service	Description of Service	Patient	Amount Owed
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
		Total:	\$ _____

Please attach documentation of services above. (i.e.: explanation of benefits from insurance carrier showing patient responsibility, proof of eligible premium payments, receipts for purchased items not covered by insurance, etc.)

I certify that the above information is accurate and represents expenses I or my dependents have incurred. I further certify that these expenses have not been reimbursed by any other benefits that may be available.

Signature of Account Holder

Date

Send to:



P.O. Box 247
704 Sand Lake Road
Onalaska, WI 54650
Fax: 608-779-3009
www.3PAdmin.com