TRISTAR
BENEFIT ADMINISTRATORS

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

1. Employee Information: Complete all sections.				
Employer Information	Name of Your Employer			
Employee Information	Employee's Last Name	First Name	Initial	Employee's Social Security No. — —
☐ Check box if new address.	Home Address			
	City	State	Zip	Daytime Phone Number

2. Health Care: An itemized statement is required including date of service, type of service, and total charge.

Please check one of the following boxes:

☐ Charges attached are partially covered benefits under my health and/or dental insurance coverage. Enclosed is an Explanation of Benefits from my insurance. An Explanation of Benefits is required even if charges are applied to your deductible or out-of-pocket liability.

☐ Charges are **not** a covered benefit by any insurance plan for which the patient is enrolled.

☐ Charges attached are for reimbursement of my office visit or prescription drug co-pay due at the time of service. My insurance company does not provide an Explanation of Benefits for these services. Enclosed is an itemized receipt provided by the provider of service.

Date(s) Incurred	Name of Person Receiving Care	Description of Expense	Provider Name (i.e. clinic, doctor, hospital)	Total Expense	Amt. Paid by Insurance	Amount Remaining
			TOTAL AMOUNT OF MEDICAL EXPENSE	$	$	$

3. Employee Certification: Employee signature required.

I certify that the above information is correct. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical expenses, which will not be paid or reimbursed under any other plan. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code.

Employee's Signature **Date**

Please send the completed claim form and appropriate statements to:

TRISTAR Benefit Administrators
P.O. Box 65887
West Des Moines, IA 50266
(800) 456-4584
Fax: (515) 453-2354
Email: flex@tristargroup.net

Reference No.:	Date:	Pend:	Date: