Affordable Benefit Administrators, Inc.
P.O. Box 10787, Burbank, CA 91510-0787
Phone (800) 350-0148 Fax (818) 842-0225

HRA Reimbursement Request Form

Instructions For Submitting A Claim:
1. Complete all information in Sections A, B and C
2. Attach detailed medical invoice documentation or Health insurance / FSA plan explanation of benefits.
3. Please make copies for your records.
4. Send completed form and supporting expense documentation to the above address.

Section A – Employee Identification

Employer: _____ Group #: _____

Employee: _____ Soc. Sec.#:_____ D.O.B. _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Section B – Medical Expense Information

Health Reimbursement Account Expenses reimburses medical expenses within IRS code 213. Eligible expenses must be reimbursed first through the Health Flexible Spending Account then through available funds in the Health Reimbursement Account.

Cash register receipts, cancelled checks, previous balance statement, paid on account receipt, etc…. are not acceptable forms of expense documentation according to the IRS as they do not clearly indicate the date of service or type of service.

Expenses Incurred For (name)	Date of Service	Provider Name	Service Type	Total Charges	Reimbursement Requested
				TOTAL REIMBURSEMENT REQUESTED	$

Section C – Employee Certification

I hereby certify that all items requested to be reimbursed have not and will not be covered by any other plan of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax return for any year.

EMPLOYEE SIGNATURE	DATE