

Health Reimbursement Account (HRA) Claim Form (Actives)

How to file a claim:

Online: Log into your benefits portal or use the MyChoice Mobile App to submit your claim electronically.

Via email, fax or mail: Fill out your form electronically and submit via email, fax, or mail.

- **Email:** claims@mychoiceaccounts.com
- **Mail:** MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax:** 855-883-8542

Instructions for filling out this form:

Complete each section in full.

If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

A EXPENSE TYPE (*indicate the type of expense that is being claimed for reimbursement*)

B START AND END DATE OF CLAIM

C AMOUNT OF CLAIM SUBMITTED

SECTION 1: YOUR INFORMATION	
SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES) 3 2 3 1 9 2 1 0 0 3	COMPANY NAME Acme Company
RETIREE LAST NAME S m i t h	HOME ZIP CODE 9 0 0 1 2
EMAIL SSmith@Acme.org	DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES) 9 1 9 1 2 4 3 1 0 9
SECTION 2: YOUR HEALTH CARE EXPENSES	
A EXPENSE TYPE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> OTHER _____	B CLAIM START DATE (MM/DD/YY) 0 2 0 1 2 0 CLAIM END DATE (MM/DD/YY) 0 2 2 8 2 0
	C AMOUNT \$ 3 2 3 . 1 9

To ensure your claim is submitted successfully:

Be sure to attach a copy of the Explanation of Benefits, or itemized invoice(s), including:

- a. The date the expense was incurred (not the date paid and no future dates)
- b. The name of service provider or carrier name
- c. A description of the service and/or expense
- d. The amount of the expense

Please Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.



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Use only **CAPITAL LETTERS**, completely fill in and use only blue or black ink.

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SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

COMPANY NAME

LAST NAME

HOME ZIP CODE

EMAIL

DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES)

SECTION 2: YOUR HEALTH CARE EXPENSES

EXPENSE TYPE

 MEDICAL VISION DENTAL PRESCRIPTION

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

\$

Carrier Name

EXPENSE TYPE

 MEDICAL VISION DENTAL PRESCRIPTION

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

\$

Carrier Name

EXPENSE TYPE

 MEDICAL VISION DENTAL PRESCRIPTION

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

\$

Carrier Name

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free.
- Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.

I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.