Gallagher | HealthInvest HRA

HI01 2/22 PRC

# Claim Form

Use this form to reimburse your qualified out-of-pocket medical expenses

**Skip this form!** Log in at **healthinvesthra.com** to submit your claims and supporting documentation online.

**Submit paper forms to:** claims@healthinvesthra.com | HealthInvest HRA, PO Box 80967, Seattle, WA 98108 | 206-686-1402 fax

## Make sure your documentation has everything we need!

Be sure to attach proof of each expense. Missing, incomplete, or illegible supporting documents are the most common reasons claims are denied. You can help avoid denied claims by making sure the proof you submit is legible and contains all five of the following:

1. **Name** of covered individual;
2. **Date** item was purchased or service was provided or Policy Periods for insurance premiums;
3. **Service Provider** name (doctor, pharmacy, hospital, etc.);
4. **Description** of the item purchased or service received; and
5. **Amount** of out-of-pocket expense

Cancelled checks, carbon copy checks, credit or debit card receipts, bank statements, and balance forward or payment on account statements do not contain all of the required information and are **not** acceptable. Common forms of acceptable documentation include:

1. **Explanation of benefits (EOB)** from your insurance company (recommended);
2. **Itemized statement** of services from your doctor or other service provider;
3. **Stub or "bag tag"** from a prescription (not the cash register receipt); or
4. **Detailed receipt** for over-the-counter medicines.

The types of expenses listed below may require a prescription, letter of medical necessity, or an EOB:

- Massage therapy
- Weight loss programs
- Health club or gym fees
- Personal trainers
- Vitamins and supplements
- Transportation and lodging on medical care
- Orthodontia (prepayment contract)

## Four easy ways to get your money back faster!

Try using our convenient electronic services.

1. **Submit your claims online**. Simply log in at **healthinvesthra.com**, click **Claims**, and follow the instructions.
2. **Use our mobile app**. Keep track of your account and submit claims on the go. Download **HRAgo**® from the App Store or Google Play. To use HRAgo, you must be registered for online account access.
3. **Set up an automatic premium reimbursement (APR)**. You don't have to submit a claim every month for your qualified insurance premiums. To set up an APR, log in at **healthinvesthra.com** and click **Claims**, or complete and submit a paper **Automatic Premium Reimbursement** form.
4. **Elect direct deposit**. Direct deposit is faster and more convenient than waiting to receive paper check reimbursements in the mail. To sign up, log in at **healthinvesthra.com**, click **My Profile**, then click **Account Preferences**.

**Go Green! Sign up for e-communication and avoid the paper clutter.** Make your election online. Log in at **healthinvesthra.com** and click **My Profile** to update your **Account Preferences.**

**Need a form or any of the resources listed above?** Log in at **healthinvesthra.com** and click **Resources**.

**Complete Claim form on reverse ▶▶**

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## 1 PARTICIPANT INFORMATION

Clear Form

If you have more than one claims-eligible account, enter the participant account number of the account from which you want to be reimbursed. Otherwise, your claim will be reimbursed from the account with the earliest claims-eligibility date.

ACCOUNT NUMBER or SSN _____ DATE OF BIRTH mm / dd / yyyy _____

LAST NAME _____ FIRST NAME _____ M.I. _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

AREA CODE and PHONE NUMBER _____ EMAIL ADDRESS (use home or personal email address) _____

**GO GREEN!** Sign up for **e-communication** and avoid the paper clutter. Make your election online. Log in at **healthinvesthra.com** and click **My Profile** to update your **Account Preferences**..

**IMPORTANT: Have you previously separated or retired from the employer that made or is making contributions to this account?**

☐ YES
☐ NO

DATE OF SEPARATION or RETIREMENT mm / dd / yyyy _____ EMPLOYER NAME _____

## 2 CERTIFICATIONS: READ BEFORE SUBMITTING

**By submitting this form , I (the participant) certify:** (1) To the best of my knowledge, all amounts listed are for qualified out-of-pocket expenses or premiums for medical, dental, vision, or long-term care. (2) For participants with full in-service benefits (claims eligibility) who are still employed by the employer who set up their HRA: Any major medical expense for my spouse or dependent was incurred while he or she was covered by an employer-sponsored group health plan. Also, any out-of-pocket premium expense is for group coverage through an employer and paid for on an after-tax basis. (3) For participants with full benefits (claims eligibility) only after separation from service: Any major medical expense was incurred while I was separated from the employer who set up my HRA. (4) Items purchased are for use by me or one or more covered individuals, and I will pay back my reimbursement if I return an item to the retailer or sell an item to a third party. (5) I agree to hold the Plan and its agents harmless for any adverse tax consequences. (6) I have read and agree to the **Terms and Conditions** in the **Plan Summary/Summary Plan Description** as amended from time to time, which is available after logging in at **healthinvesthra.com** and clicking **Resources**.

## 3 EXPENSE INFORMATION

Submitting expenses for your spouse or a dependent? Please enter his or her name, Social Security number, and date of birth in the Covered Individual column.

| Covered Individual | Date of Service | Expense Amount |
|---|---|---|
| ☐ Self ☐ Spouse ☐ Dependent<br>Spouse/Dependent Name: _____<br>SSN: _____ DOB: _____ | | |
| ☐ Self ☐ Spouse ☐ Dependent<br>Spouse/Dependent Name: _____<br>SSN: _____ DOB: _____ | | |
| ☐ Self ☐ Spouse ☐ Dependent<br>Spouse/Dependent Name: _____<br>SSN: _____ DOB: _____ | | |

**Have more expenses?** Use another form or include an itemized list on a separate sheet of paper.