Capital Administrators
A Division of Capital Region Benefits

HRA

HEALTH REIMURSEMENT ARRANGEMENT
REIMBURSEMENT REQUEST FORM

IMPORTANT – This form MUST be completed to receive reimbursement for out-of-pocket medical expenses from your HRA Account(s). These services MUST have been incurred during the current Plan Year. **A copy of your insurance company's "Explanation of Benefits" verifying the date and the cost of service MUST be attached to this form.** *Your claim will not be processed until these items are received*

RETURN COMPLETED FORM AND ALL DOCUMENTATION TO:

CAPITAL ADMINISTRATORS (A Division of Capital Region Benefits)
3819 Market Street
Camp Hill, PA 17011 Email: admin1@crbenefits.net
Phone (717) 975-9300 Fax (717) 975-9303

*** * Explanation of Benefits (EOB) MUST Be attached to this claim form * ***

EMPLOYEE INFORMATION			
	EMPLOYER NAME:		**PLAN YEAR:**
	EMPLOYEE LAST NAME:	**FIRST NAME:**	**MI:**
	ADDRESS:		**PHONE: ( )**
	CITY:	**STATE:**	**ZIP:**
	DATE OF BIRTH:	**E-MAIL:**	**SSN: - -**

DEPENDENT INFORMATION
(PLEASE LIST ALL COVERED DEPENDENTS ENROLLED ON YOUR PLAN)

	First Name	Last Name	Date of Birth	SSN
Spouse				
Child				
Child				
Child				
Child				

EXPLANATION OF BENEFITS MUST BE ATTACHED
CREDIT CARD RECEIPTS, CANCELLED CHECK COPIES, OR PROVIER INVOICES WILL NOT BE ACCEPTED.

CLAIMS MUST BE SUBMITTED IN ACCORDANCE WITH THE RUN-OUT PROVISIONS DEFINED ON SCHEDULE A OF THE SUMMARY PLAN DESCRIPTION. CLAIMS NOT SUBMITTED IN ACCORDANCE WITH THE RUN-OUT PROVISION MAY BE DENIED FOR UNTIMELY SUBMISSION.

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Healthcare Reimbursement Arrangement Account. I am claiming reimbursement only for eligible expenses incurred by myself, or any eligible tax dependent(s), and certify that these expenses have not been reimbursed under this Plan or by any other source and that they will not be reimbursed by any other source or insurance. I hereby authorize my HRA Account to be reduced by the amount(s) shown above.

Participant's Signature **Date**

Submit this claim form and supporting documentation to the address / fax / email at the top of this form.