

HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM



Employee Name: _____ Soc Sec #: _____

Mailing Address: _____

Telephone Number(s): _____

Employer Name: _____

IMPORTANT: Copies of invoices and the Explanation of Benefits from your insurance company, if applicable, must accompany claims for medical expense reimbursement. These documents must indicate the type of service provided the date of the service/purchase, for whom the service was provided, and the amount paid for the service. All claims submitted without proper documentation will be delayed until the appropriate documentation is received.

<i>Date of Service</i>	<i>Name of Service Provider</i>	<i>Type of Service</i>	<i>Person Service For</i>	<i>Amount</i>

READ CAREFULLY

The undersigned participant in the plan certifies (i) that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the HRA Plan with respect to such expenses; and (ii) that he/she has not been reimbursed and will not seek reimbursement from another source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

Employee's Signature

Date



Please submit completed form to:
 EBSC – Fringe Claims Dept
 940 Industrial Drive South, Suite 111
 Sauk Rapids, MN 56379
Phone: 320-257-8123
Fax: 320-257-8127
Email: Claims@EBSC-online.org

Partial List of Medical Expenses Qualifying for Reimbursement

Only Expenses **NOT** reimbursed by insurance, or some other source, can be claimed.

Acupuncture	Neurologist
Alcoholism treatment	Nursing services
Ambulance services	Obstetrician
Anesthetists	Operating room expenses
Artificial limbs	Operations (non-cosmetic)
Artificial teeth	Ophthalmologist
Bandages	Optician
Breast reconstruction surgery (mastectomy)	Oral Surgery
Blood tests	Orthopedic Shoes
Braces	Orthopedist
Braille books/magazines	Osteopath
Car modifications required for accessibility	Oxygen (equipment for breathing problems)
Cardiographs	Pediatrician
Chiropractor	Physician
Christian Science Practitioner	Postnatal treatments
Contact lenses (Including cost of materials)	Prenatal care
Contraceptives	Prescriptions
Crutches	Prosthesis
Dental treatment (no cosmetic-teeth whitening)	PSA test
Dermatologist	Psychiatric care
Diagnostic devices and fees (including blood sugar tests for diabetics)	Psychoanalysis
Drug addiction therapy	Registered nurse
Eyeglasses (including exam fees)	Psychologist
Eye surgery (including laser correction treatments)	Splints
Fertility treatments	Sterilization
Guide dogs	Stop smoking programs (except non-prescription drugs)
Gynecologist	Surgeon
Hearing aids (including batteries)	Therapy
Hospital services	Transplants
Insulin	Transportation essential to medical care
Insurance premiums (if not paid on a pre-tax basis)	Vaccines
Laboratory tests	Vasectomy
Lead based paint removal (removal only)	Vision correction surgery
Legal fees required for mental illness treatment	Weight loss programs (only amount related to treatment for specific diseases)
Medical services	Wheelchairs
Medicines (prescribed and over the counter)	X-rays

Partial List of Non-qualified Medical Expenses

Advance payments for future medical expenses	Diet foods
Car expenses associated with operating a specially equipped car	Electrolysis or hair removal
Child care	Funeral expenses
Cosmetic procedures	Hair removal and transplants
Cosmetics and hygiene products	Illegally procured drugs, operations, treatments
Dancing lessons	Late fees for late payments for medical services
Dietary, Nutritional supplements	Vitamins