Health Reimbursement Arrangement (HRA) Claim Form

Employee Information

Employee Name

Employee ID

Employer Name

Address

City

State

Zip Code

Claim Details

Patient Name

Relationship to Employee

Date(s) of Service

Provider Name

Description of Service/Expense

Amount Requested

Other Relevant Details

Certification

I certify that the expenses listed above are eligible for reimbursement under my employer's HRA plan, have not been reimbursed, and will not be submitted for reimbursement elsewhere.

Employee Signature

Date