Claim Form

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

HRAveba

HV01 7/20 PRC

Skip this form! Log in at **HRAveba.org** and submit your claims and supporting documentation online.

Submit paper forms to: claims@hraveba.org | HRA VEBA Plan, PO Box 80587, Seattle, WA 98108 | 206-577-3020 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 and prescription** for over-the-counter medicines (required only if purchased before January 1, 2020).

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 **HRAveba.org**, click **Claims** on the menu bar, 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 **HRAveba.org** and click **Claims** on the menu bar, 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 **HRAveba.org**, click **My Profile** on the menu bar, then click **Account Preferences**.

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

Need a form or any of the resources listed above? Log in at **HRAveba.org** and click **Resources** on the menu bar.

Complete Claim form on reverse ▶▶

Claim Form

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

HRAveba.

HV01 7/20 PRC

Skip this form! Log in at **HRAveba.org** and submit your claims and supporting documentation online.

Submit paper forms to: claims@hraveba.org | HRA VEBA Plan, PO Box 80587, Seattle, WA 98108 | 206-577-3020 fax

1 PARTICIPANT ACCOUNT AND CONTACT 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 **HRAveba.org** 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 completing and submitting this form, you certify all of the following is true:

- You agree to the **Terms and Conditions**, as amended from time to time, which can be found in the **Plan Summary**. To get a copy, log in at **HRAveba.org** and click **Resources** on the menu bar, or contact our Customer Care Center at customercare@hraveba.org or 1-888-659-8828.

If your claim is for dental, vision, or qualified long-term care, disregard the below and skip to Section 3. The following applies only for all major medical claims.

- **For Standard HRA plan participants who are still employed**: Any major medical expense for your spouse or dependent was incurred while he or she was covered by an employer-sponsored group health plan. Also, any premium expense listed in Section 3 of this form is for group coverage (purchased through an employer) and not for an individual plan or private market medical coverage. You must elect limited HRA coverage for your spouse and/or dependents for any period of time during which they are not covered by an employer-sponsored group health plan. See our **Limited HRA Coverage Election** form for more details.
- **For Post-separation HRA plan participants**: Any major medical expense to be reimbursed from a post-separation HRA was incurred while you were separated or retired (not employed or re-employed) from the employer that made or is making contributions to your HRA.

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 Spouse/Dependent Name: _____ SSN: _____ DOB: _____		
☐ Self ☐ Spouse ☐ Dependent Spouse/Dependent Name: _____ SSN: _____ DOB: _____		
☐ Self ☐ Spouse ☐ Dependent Spouse/Dependent Name: _____ SSN: _____ DOB: _____		

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