

HRA Claim Form



Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print when using this form
- Minimum Total Reimbursement = \$25
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

****Notice****
All over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulations

1 Personal Information

Employee Name (First Name, Last Name) _____ Company Name _____

Street Address _____ City _____ State _____ Zip Code _____ No Yes
Address Change?

Phone Number _____ Social Security Number _____

2 HRA Claims

	Date of Service			Provider	Service Rendered	Person Receiving Service	Amount
	MM	DD	YY				
1	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____	_____	_____
Total Health Care Expense							_____

3 Eligible Expenses

Please see your current SPD for a summary of your benefit

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____