

**HEALTH REIMBURSEMENT ACCOUNT
REIMBURSEMENT CLAIM FORM**



Employee Instructions:

1. Reimbursement form must be complete and clear. **Failure to answer any questions or provide proper documentation may delay payment.**
2. Attached **ALL** pages of your Explanation of Benefits (EOB).
3. Bills from your doctor or other service providers **will not be accepted.**

Participant Information	
Employer: _____	
Employee Name: _____	Date of Birth: ____ / ____ / ____
Street Address: _____	<input type="checkbox"/> Check if new address
City: _____	State: _____ Zip Code: _____
Email Address: _____	<input type="checkbox"/> Check if new email address
<p>To the best of my knowledge and belief, this Health Reimbursement Claim form is complete and true. I certify that the member has received the services described above on the date of service indicated and that the expenses qualify as a valid medical service under my Employer Benefit Plan. If the expense is for my spouse or dependent, I certify that the person's receipt(s) meets the definition of dependent/spouse in the Plan. I certify that I have not been reimbursed previously for these expenses under any other Flexible Spending Account or Benefit Plan. I understand that these expenses may not be used to claim any federal income tax deduction or credit.</p>	
Participant Signature (Required) _____	
Date: _____	

Name of Person Receiving Service	Relationship to Employee	Type of Service	Reimbursement Requested
_____	_____	<input type="checkbox"/> Medical Deductible <input type="checkbox"/> Co-Insurance Reimbursement <input type="checkbox"/> Copay	\$
_____	_____	<input type="checkbox"/> Medical Deductible <input type="checkbox"/> Co-Insurance Reimbursement <input type="checkbox"/> Copay	\$
_____	_____	<input type="checkbox"/> Medical Deductible <input type="checkbox"/> Co-Insurance Reimbursement <input type="checkbox"/> Copay	\$
_____	_____	<input type="checkbox"/> Medical Deductible <input type="checkbox"/> Co-Insurance Reimbursement <input type="checkbox"/> Copay	\$
_____	_____	<input type="checkbox"/> Medical Deductible <input type="checkbox"/> Co-Insurance Reimbursement <input type="checkbox"/> Copay	\$
Total Reimbursement Requested:			\$

Please note this is a generic use form and your Employer Benefit Plan may not reimburse Deductible, Co-Insurance and/or Copays. Please refer to your benefit plan for your specific plan reimbursement schedule.

How to Submit Claims		
Electronically: Email: hra@varipro.com	By FAX: FAX Number: 616-285-9965 Number of Pages: _____	By Mail: Varipro 5300 Patterson Ave SE, Suite 150 Grand Rapids, MI 49512

Customer Service: 800-732-3412