Claim Form

Skip this form! Log in at **hraveba.org** and submit your expenses and documentation online.
Read instructions and helpful information on reverse. Use a separate form for each covered individual.

HV01

SUBMIT COMPLETED FORM TO:
claims@hraveba.org | Fax: (206) 577-3020 | HRA VEBA Plan, PO Box 80587, Seattle, WA 98108

Do not use this form to submit supporting documentation for My Care Card transactions. If you have received a request to submit supporting documentation for a My Care Card transaction, please log in at **hraveba.org** and click **My Care Card** on the menu bar, or log in to the mobile app, **HRAgo**, and select the **My Care Card** tab on the navigation bar.

1 PARTICIPANT ACCOUNT AND CONTACT INFORMATION

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. _____

HAVE YOU PREVIOUSLY SEPARATED OR RETIRED FROM THE EMPLOYER THAT MADE/IS MAKING CONTRIBUTIONS TO THIS ACCOUNT?

☐ YES ☐ NO

DATE OF SEPARATION OR RETIREMENT MM / DD / YYYY _____

EMPLOYER NAME _____

☐ **CHECK HERE IF YOUR PHONE NUMBER, EMAIL, OR MAILING ADDRESS HAS CHANGED. PLEASE PROVIDE UPDATES BELOW:**

AREA CODE and PHONE NUMBER _____ EMAIL ADDRESS (use home or personal email address) _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

☐ **E-COMMUNICATION:** Please check the box and enter your email address in the update box at the left to receive e-statement notifications, newsletters, EOBs, and notices by email. Read details on reverse.

2 REQUIRED PARTICIPANT SIGNATURE AND CERTIFICATION

I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of this submitted claim is an accurate statement of my (a) unreimbursed medical/dental/vision expenses after payment by insurance (if any) and/or (b) medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized on the reverse and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by an employer, and are not eligible for pre-tax deduction through my employer's section 125 cafeteria plan. I acknowledge and agree that any claim submitted fraudulently could result in my termination from the Plan and/or other legal action.

☐ **Post-separation HRA Participants Required Certification:** If this claim is to be reimbursed from a post-separation HRA account, check the box to certify that you were not employed (or re-employed) by the employer that made or is making contributions to your account on the date any of the following medical care expenses were incurred. **Failure to provide this required certification will cause your claim reimbursement to be delayed or denied.**

X _____ DATE MM / DD / YYYY _____ PHONE NUMBER WHERE I CAN BE REACHED _____

PARTICIPANT SIGNATURE

3 PATIENT INFORMATION (COVERED INDIVIDUAL)

THIS CLAIM IS FOR: (choose one)

☐ Myself ☐ Legal spouse
☐ Qualifying Child ☐ Qualifying Relative
☐ Other: _____

LAST NAME _____ FIRST NAME _____ M.I. _____

☐ Male ☐ Female

DATE OF BIRTH MM / DD / YYYY _____ SOCIAL SECURITY NUMBER _____

4 REIMBURSEMENT REQUEST FOR QUALIFIED OUT-OF-POCKET EXPENSES

REMINDER: You must include proof of each expense (e.g. Explanation of Benefits (EOB), detailed receipts, etc.). Claims for employee-paid premiums deducted after tax require a letter from the employer confirming that no pre-tax option exists.

	DATE OF SERVICE	SERVICE PROVIDER or ITEM PURCHASED FROM	TYPE OF SERVICE or ITEM (Office visit, Rx, Dental, etc.)	AMOUNT YOU PAID
1				$
2				$
3				$
4				$

HAVE MORE EXPENSES? Include an itemized list on a separate sheet of paper.

Please add up your expenses to verify the total.
Total Reimbursement Request $

QUESTIONS? 1-888-659-8828 | customercare@hraveba.org | hraveba.org

Important information and helpful tips on reverse ▶

Want to know more? First time submitting a claim?

Get your money back fast

Following the tips and instructions below will help you submit "clean" claims for faster processing. For more detailed guidelines, read **How to File a Claim** available online after logging in at **hraveba.org**. Standard processing time is **five to seven business days** from the date received. If you're not signed up for direct deposit, remember to allow additional time to receive your paper checks in the mail. Email (recommended), fax, or mail your completed Claim Form and proof of expense(s) to the Plan as indicated at the top of the Claim Form.

Enter your participant account number

If you have more than one claims-eligible participant account, include 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.

Fully complete each section of the Claim Form

Missing information, particularly in section 3, will likely result in denied claims. Federal law requires the Plan to have on file the full name, Social Security number, gender, and date of birth of all covered individuals.

Submit proof of expense

Make sure you attach proof of each expense. Missing, incomplete, or illegible forms of documentation 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 of the following:

1. **Name** of covered individual who received the item or service;
2. **Date** item was purchased or service was provided;
3. **Service Provider** name (e.g. 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 are **not** acceptable. Proper proof includes:

1. **Explanation of benefits (EOB)** from your insurance company (recommended);
2. **Itemized statement** of services from your doctor or other service provider;
3. **Stub** from a prescription (not the cash register receipt); or
4. **Detailed receipt and prescription** for over-the-counter medicines.

Certain claims, such as insurance premiums, dental/orthodontia, and massage therapy require additional proof. For more details read the **How to File a Claim** handout available online after logging in at **hraveba.org** or upon request from the customer care center.

Reimburse your qualified insurance premiums automatically

You don't have to submit a Claim Form every month for your qualified insurance premiums. Automatic premium reimbursement (or payment) is available. Simply complete and submit an **Automatic Premium Reimbursement** form. Forms are available online after logging in at **hraveba.org** or upon request from the customer care center.

HELPFUL CHECKLIST:

- ☐ Attach legible proof of each expense - use an EOB whenever possible.
- ☐ Enter the correct account number.
- ☐ Sign your Claim Form.
- ☐ Keep copies of completed Claim Form and attachments for your files.
- ☐ Do not submit more than one receipt for each expense.
- ☐ Handwritten receipts must have provider information stamped on them.
- ☐ If you want to note certain items on your receipts, circle the items - do not use a highlighter.

Important Information

E-communication:
If you have elected e-communication, please note that after logging in at **hraveba.org**, you (1) may withdraw your consent for electronic documents at any time without charge by updating your account preferences; (2) will be able to view and print copies of electronic documents (you may request paper copies at no charge by contacting the customer care center); and (3) can update your email address on file by updating your personal information. To access electronic documents, you will need a copy of Adobe Acrobat Reader software loaded on your computer. You can download and install a free copy at www.adobe.com. Documents provided electronically will not be mailed via U.S. Mail.

Qualified expenses and premiums:
Medical expenses you submit for reimbursement must be incurred after you become and remain claims-eligible. Common qualified expenses include co-pays, coinsurance, deductibles, and prescriptions. Qualified insurance premiums include medical, dental, vision, tax-qualified long-term care (subject to IRS annual limits), Medicare Part B, Medicare Part D, and Medicare supplement plans. IRS regulations provide that insurance premiums paid by an employer, deducted pre-tax through a Section 125 cafeteria plan, or subsidized by the Premium Tax Credit are NOT eligible for reimbursement. For more details, read **Qualified Expenses and Premiums**, **How to File a Claim,** or **Facts About Premium Tax Credit Eligibility** available online after logging in at **hraveba.org** or upon request from the customer care center.

Legal spouse and dependent coverage:
The HRA VEBA Plan covers you, your legal spouse, and qualified dependents. A legal spouse includes anyone you have legally married, so long as the marriage occurred in any U.S. or foreign jurisdiction that recognized the marriage, regardless of where you live now. Generally, dependents must satisfy the IRS definition of "qualifying child" or "qualifying relative" as of the end of the calendar year in which expenses were incurred. Effective September 1, 2010, your young adult children's expenses incurred through the end of the calendar year in which they turn age 26 are eligible for reimbursement. See **Definition of Dependent** at **hraveba.org** for more details.

Multiple investment funds:
If your account is allocated among multiple investment funds, reimbursements (claims) will be deducted pro rata based on your balance in each fund at the time of reimbursement unless you request otherwise in writing.

Medicare coordination:
Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires the HRA VEBA Plan to report specific information about Medicare beneficiaries covered under the Plan. The purpose of this reporting is to assist the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees the Medicare program, coordinate the payment of benefits with other group health plans, such as your HRA VEBA Plan. Federal rules determine whether Medicare or HRA VEBA Plan should pay first. Generally, your HRA VEBA Plan account is primary to Medicare if you're still employed by the employer that made (or is making) contributions to your HRA VEBA Plan account. For more details, read **Who pays first, the HRA VEBA Plan or Medicare?** available online after logging in at **hraveba.org** or upon request from the customer care center.