



HRA REIMBURSEMENT FORM

MAIL or FAX claims to BASIC at:
9246 Portage Industrial Drive, Portage, MI 49024
Fax: 269-327-0716 or 800-391-6562
For questions Call: 269-327-1922 or 800-444-1922 x 1

Company Name: _____

Employee Name: (Please print or type): _____

Social Security Number: _____ Phone: _____

My NEW address is: _____

E-MAIL ADDRESS: _____

MEDICAL EXPENSES

Date of Service	Physician or other Provider	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL MEDICAL EXPENSES TO BE REIMBURSED \$ _____

I certify that the statement and information on this reimbursement form are accurate and true. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I further certify I will not claim these, or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties out of any disallowed deduction/credit.

*****Employee Signature: _____ Date: _____

You must sign this form to be reimbursed.

FOR ADMINISTRATIVE USE ONLY

Reviewed By: _____ Date: _____ Plan Year: _____ Approved: \$ _____ Denied: \$ _____

Reason for Denial: _____ Action: _____

INSTRUCTIONS FOR MEDICAL AND DEPENDENT CARE REIMBURSEMENT ACCOUNTS

- Only employees participating in the plan can submit a reimbursement form.
- Employees may be reimbursed from the plan at any time during the plan year.
- Reimbursements may only be made for eligible expenses incurred during the plan year.
- Complete the information on the reimbursement form for each amount claimed.
- If you receive reimbursement for expenses, you may not claim these expenses for income tax purposes.
- **You must sign the form**, thereby swearing that you have not and will not submit these expenses for reimbursement from another plan.
- Submit your reimbursement form and documentation to BASIC, 9246 Portage Industrial Drive Portage MI 49024, or fax to 269-327-0716 or 800-391-6562 or e-mail basic@basicflex.com.

MEDICAL REIMBURSEMENT ACCOUNT

- Documentation must be invoices or other written statements from the third parties that provided the services.
- **The documentation must show the providers name and address, the dates the services were provided, the amounts charged for the services, and a brief description of the services.**
- **For services that you have insurance coverage, you MUST submit the Explanation of Benefits from your insurance company.**
- If a covered benefit by your HRA, orthodontics cannot be reimbursed for the entire amount. Claims for the initial down payments usually associated with the appliances and monthly payments will be accepted as the charge for the medical service rendered for the month.