ebms
CONSUMER DRIVEN HEALTHCARE

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Request for HRA Reimbursement

Employer Name		Employer Group Number
Employees Last Name	First Name	Employee's ID Number
Address		E-mail Address

Medical Expenses

Date of Service	Provider	Description of expense (office visit, deductible, co-pay, prescription, etc.)	Patient Name	Amount Requested
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
		Total amount requested		$

To the best of my knowledge and belief, my statements in the Request for HRA Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. The expense(s) has not been reimbursed or is not reimbursable under any other health plan coverage and will not be claimed as an income tax deduction. I authorize my Health Reimbursement Arrangement account to be reduced by the amount requested above.

Employee Signature: _____ Date: _____