HRA Reimbursement Request

P.O. Box 21367 Billings, MT 59104-1367

Phone: 866.857.8182 F a x : 844.791.8315 Email: EBMS_receipts@alegeus.com

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

You must include supporting documentation from the provider so that your claim can be processed timely. Documentation must legibly show the patient's name, date of service, service provider name, total amount owed (including insurance amounts if applicable), and the eligible service or product. Prescription claims require the RX tag that includes the fill date, RX number, patient name and the amount owed. ***Note: Credit card receipts, balance due statements, cancelled checks and "estimated" insurance references are not acceptable forms of documentation***

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 applicable plan year and for eligible plan participants. The expense(s) has (have) not been reimbursed or is (are) 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: _____