HRA Claim Form (HRA)

If faxing, # of Pages: _____

EMPLOYEE INFORMATION (PLEASE PRINT)

Name: _____ SSN: _____

Address: _____ Email: _____

City, State, Zip: _____ Day Phone: _____

☐ Check here if address has changed

UNREIMBURSED HEALTHCARE EXPENSES (ATTACH SUPPORTING DOCUMENTATION)

Does your receipt include all of the following?

- Provider's name and address
- Service description
- Date of service
- Patient's name
- Amount billed

*** Credit card receipts are not acceptable ***

Person for Whom Expense was Incurred	Date of Service	Name of Service Provider	Description of Services	Amount
			Total Unreimbursed Healthcare Expenses	

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a Health Savings Account (HSA). I understandthat I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

Participant Signature: _____ Date: _____

Complete this form and mail it to: PO BOX 161357 Altamonte Springs, FL 32716, or Fax it to: 844.791.8317 (TFN) or 978.856.6612 (Local)
For assistance, call 844.769.2738 or send an email to: service@mycreatehealth.com

Access your account information 24 hours a day, seven days a week on our web site: www.mycreatehealth.com