



3505 Cadillac Avenue, #O-201
 Costa Mesa, CA 92626
 Attn: HRA Administration
 Fax: 714-437-1142

EBA&M USE ONLY

HRA REIMBURSEMENT REQUEST FORM

EMPLOYER NAME	GROUP NUMBER

EMPLOYEE NAME (LAST, FIRST)	SSN#	DATE OF BIRTH
ADDRESS	CITY/STATE	ZIP CODE

CHECK IF NEW ADDRESS

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO VALIDATE ALL REIMBURSEMENT SUBMISSIONS. DOCUMENTATION MUST BE A COPY OF YOUR EXPLANATION OF BENEFITS (EOB) FROM YOUR CARRIER.

LIST OF REIMBURSEMENT REQUESTS ATTACHED:

Provider Name	Date of Service	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the information reported on this form is correct and that I have not previously received reimbursement for these charges from this or any other plan of coverage. I understand that these expenses may not be claimed for credit or deduction on my personal income tax return.

EMPLOYEE SIGNATURE	DATE

We reserve the right to review any or all documentation sent in for reimbursement. Further information may be requested to substantiate your claim. All requests for further documentation will be made in writing and sent to the current address on file within 15 days of receiving the claim.