EBA&M
EMPLOYEE BENEFITS
ADMINISTRATION & MANAGEMENT

18002 Cowan
Irvine, CA 92614
Attn: HRA Administration
Fax: 714-437-1142

| EBA&M USE ONLY |
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# 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 |
| --- | --- | --- |
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I hereby certify that the information reported on this form is correct and that I have not previously recevied 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 documentation sent in for reimbursement. Further informtion 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 this claim.*