



**UCP OF MAINE
HRA REQUEST FOR REIMBURSEMENT**

I. Participant Identification

(Please print or type)

Participant Name: _____

Social Security Number: XXX - XX - _____

II. Invoices attached

(Please attach a separate sheet if more space is needed)

Date of Service Physician or other Provider Amount

_____	_____	\$ _____.
_____	_____	\$ _____.
_____	_____	\$ _____.
_____	_____	\$ _____.

III. Total Amount Requested \$ _____.

IV. Statement by Participant

The medical expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other health plan coverage, including other medical flexible spending arrangements.

Participant's Signature

Date

For Administrative use only

Reviewed by: _____

Date: _____

Plan code: _____

Employee number: _____

Plan Year: ____

Benefit code: _____

Approval

Trans. type: ____

As of: __/__/__

Approved: \$ _____.

Denial

Trans. type: ____

As of: __/__/__

Denied: \$ _____.

Reason for Denial: _____

Action to be taken: _____

HEALTH REIMBURSEMENT ARRANGEMENT REIMBURSEMENT REQUEST FORM

Explanation to Participants

To submit a request for reimbursement, you must complete this form, sign it and attach the documentation needed to verify that your expenses are qualified for reimbursement under the Plan. Return the completed form with the documentation attached to your Benefits Coordinator.

**** Invoices Attached ****

Please list the invoices or statements which are attached. These documents must be invoices or other written statements from the third parties who provided the medical services and must show the names of the providers, the dates that services were provided, the amounts charged for the services, and a brief description of the services. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Expenses must be for services that you received during the same period that you are an HRA Participant. For example, if your enrollment begins on February 1, you can submit a claim for a February 1 doctor's visit, but not for a doctor's visit on January 31, even though you don't receive a bill until February 15.

**** Total Amount Requested ****

Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached.

**** Statement by Participant and Signature ****

Besides providing the information that is needed to prove that your claim is for qualified for reimbursement, you must sign the form, thereby swearing that you have not and will not submit these expenses for reimbursement from another Plan. For example, if you are covered by more than one medical insurance policy or more than one medical flexible spending arrangement, you cannot receive a reimbursement from this Plan and from the other Plan, too.