PROGRESSIVE BENEFIT SOLUTIONS, LLC

Request for Reimbursement

HRA CLAIM FORM (01/2009)

Employer Name: _____

Employee Name:	Last First MI	**SS#**	
Address:	Street City State Zip	**Phone:**	( )

☐ **Please check if this is a new address**

NOTE: Information below must be completed

HRA CLAIMS

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						$
						$
						$
						$
						$
						$
						$
						$
					Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my account were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ /_____ /_____

FOR FASTEST REIMBURSEMENT, FAX TO 203-234-1139

OR MAIL TO: PROGRESSIVE BENEFIT SOLUTIONS, LLC - 23 MAIDEN LANE, NORTH HAVEN, CT 06473

** Procedure for filing a Request for Reimbursement

1. Obtain an Explanation of Benefits (EOB) from your insurance carrier for deductible-related, medical services received.

2. Complete, entirely, the above Request for Reimbursement – HRA Manual Claim Form.

3. Attach the Explanation of Benefits to this Form.

4. Fax to PBS at 203-234-1139 or mail (see PBS Address Above) this Form with the EOB to Progressive Benefits.