

HRA/MERP Reimbursement Claim

Fax To: (877) 329-3539

Participant Name:

Address:

Street

City

St.

Zip

Social Security #:

Day Phone:

Employer:

Email Address:

Important: In order to receive reimbursement, you must attach the Explanation of Benefit (EOB) provided by your insurance company. The EOB must include the following: Date(s) of Service, Type of Service, Amount applied to the deductible and the Name of the Service Provider.

Indicate date(s) of service, not payment dates
Date From
Date To
Amount

Please apply any remaining balance to my Health FSA. (Only applicable when ProBenefits is also the Service Provider for the FSA.)

For Direct Deposit Reimbursements, please tape a Voided Check.
If you have provided this with an earlier request, you do not need to resubmit.

(If no voided check is attached, a paper check will be printed and mailed)

By attaching a voided check, I hereby acknowledge the following:
 I hereby authorize ProBenefits (hereinafter Plan Service Provider) to initiate credit entries (electronic and otherwise) and, if necessary, debit entries and adjustments for any erroneous credit entries posted to my Personal Bank Account. This authority is to remain in full force and effect until the Plan Service Provider has received written notification from me of its termination in such time and manner as to afford Plan Service Provider and Financial Institution a reasonable opportunity to act on it. I can discontinue this arrangement at any time and receive reimbursements by check.

Comments:

Certification: These expenses were incurred (have a date of service) during the plan year while I have been a covered participant. I certify that these expenses were incurred for eligible members of my family or me and they have not been reimbursed from any other health insurance coverage or plan. I also understand that privacy concerns, ProBenefits may not discuss claim information with anyone other than the participant.

Signature : _____ Date: _____

