



Health Reimbursement Arrangement Reimbursement Claim Form

Employee Name: _____

Social Security Number: _____

Phone: _____

E-mail: _____

Health Reimbursement Arrangement Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➔ Attach appropriate receipt(s) and submit with this claim form.			Total Health Reimbursement Arrangement Expense Claim	\$

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Your Health Reimbursement Arrangement (HRA) Plan may be limited by the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan for a list of eligible expenses.

Employee's Signature

Date

Mail Claim Form and Receipts to:

MVP Ancillary Services Division
Flex Care Program
620 Erie Blvd. West #200
Syracuse, NY 13204

Health Reimbursement Arrangement

Claim Form & Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

When filing your claim, you must attach copies of the receipts. **The receipt must show the date and type of service for the expense.** Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

If you choose to **mail** your claim with receipts, the address is MVP Ancillary Services Division, Flex Care Program, 620 Erie Blvd. West #200, Syracuse, NY 13204. *(Please remember to keep a copy of the claim form and supporting documents for your records.)*

If you choose to **fax** your claim with receipts, the fax number is 315-234-6146. After you fax a claim and receipts, please **do not** follow-up with a hard copy in the mail. *(Remember to keep the original claim form and supporting documents for your records.)*
