MMSI

Health Reimbursement Account **Claim Form**

- Eligible health care expenses include services incurred by you, your spouse or your dependent as defined by the Internal Revenue Service Code. Expenses must be incurred during the period of coverage for which you made your election. Expenses are incurred on the date services are provided, not when services are paid for or when a service is billed.
- In order to process your claim, MMSI must receive proper documentation and this completed Health Reimbursement Account claim form. Examples of proper documentation include receipts, billing statements, Explanation of Benefit statements or benefit denial correspondence. Documentation must be itemized and include the incurred dates of service. Documentation will not be returned. **Balance due statements and cancelled checks are not acceptable documentation.** Refer to your plan documentation for more information.
- If you have a medical flexible spending account (FSA), your HRA may pay primary or secondary to your medical FSA.
- Refer to your plan documents for further details.

Mail to: HRA Claims – MMSI
307 International Circle
Suite 200
Hunt Valley, MD 21030

Fax: 1-866-879-0812

SECTION I

Last Name (Account Holder)	First Name	Middle Initial		Employer Name
Street Address	Last 4 Digits SSN		Date of Birth	Home Phone #
City	State	ZIP		Work Phone #

Date(s) of service	Description of eligible expenses	Name/Relationship of individual receiving care	Name of Provider	Amount to be reimbursed
Jan. 1, 2005	**Example: Chiropractic**	*Jane/Spouse*		*$75*
			Total	

SECTION II – Account Holder Certification

I authorize the above-listed expenses to be reimbursed through my Health Reimbursement Account. I certify that my statements in this form are true and complete to the best of my knowledge. I further certify that the above-listed expenses have not been reimbursed or paid by any other source, and that I will not seek reimbursement for them from any other source. I further certify that the above-listed expenses will not be claimed as a deduction or credit for federal or state income tax purposes. I further certify, to the best of my knowledge, that the above-listed expenses qualify as eligible expenses under the Health Reimbursement Account and that the person receiving the care identified above is either me or my Spouse or Dependent (as those terms are defined in the plan documents).

Signature of Account Holder _____ Date _____