MAYO CLINIC

Health Reimbursement Account Claim Form

Mayo Clinic Health Solutions

Please complete, print and submit.

Reset Form

- Eligible health care expenses include services incurred by you, your spouse or your dependent as dened 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, Mayo Clinic Health Solutions 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 benet 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 health care flexible spending account (FSA), your HRA may pay primary or secondary to your health care FSA.
- Refer to your plan documents for further details.

Mail: Health Reimbursement Account Claims
Mayo Clinic Health Solutions
PO Box 211698
Eagan, MN 55121

Fax: 1-855-619-0010

Section I

Last Name *(Account Holder)*	First Name	Middle Initial	Employer Name

Address	City	State	Zip Code

Birth Date	Social Security Number *(last 4 digits)*	Home Phone Number/Work Phone Number

Date of service	Description of eligible expenses	Name/Relationship of individual receiving care	Total amount of bills	Name of Provider	Amount to be reimbursed
1/12/14	**Example:** Coinsurance	Jane/Spouse	$75		$75
				Total	

Section II – Account Holder Certification

I certify that the expenses listed above qualify for reimbursement under IRS guidelines (Publication 969) and have been incurred by me or eligible members of my family. I understand that I am responsible for the validity of claims submitted to my Pre-tax Accounts, and that these expenses occurred during my coverage period, within the plan year. I certify that these expenses were not for cosmetic or general health purposes, and any products claimed do not constitute toiletries/cosmetics. I certify that these expenses have not been reimbursed under the above mentioned accounts or by any other source, and will not be claimed as deductible expenses when I file my personal tax returns. Furthermore, I understand that I am responsible for retaining copies of valid receipts for a period of 3 tax years per IRS guidelines. I will provide valid receipts of service where required and authorize the appropriate Pre-tax Account to be reduced by the amounts shown above. I understand that all reimbursement received from my Pre-tax Accounts will be paid directly to me and that I am responsible for any taxes or penalties that may arise in the event that I request and receive reimbursement that does not qualify for tax deductibility under federal or state law.

Signature of Account Holder Signature Required Date

Print