HRA Claim Form

Today's Date: ____/____/____ # of pages: _____ Plan Year: 20 _____

❑ New Claim ❑ Response to Claim Denial

Employee Name: Employer Name/Division Name:		Employer Name/Division Name:
Employee Address: ☐ Please check if change of address; you must also change with your HR department.		
Social Security Number or Member ID Number:	Work Phone: ( )	Home Phone: ( )

**Minimum check reimbursement is $25; minimum reimbursement for direct deposit is .50*

❑ **Health Reimbursement Arrangement (HRA)** **Total Amount Requested:** _____

Date of Service	**E**mployee, **S**pouse or **D**ependent	Amount Requested	Type of Service (R_x, co-pay, dental expense, etc.)	Service Provider Number/ R_x Number
1.				
2.				
3.				
4.				
5.				

I certify that the above listed expenses have been incurred by me or by my spouse or dependent(s) and that they have not been reimbursed under any other health plan; furthermore, I will not seek reimbursement of the expenses under any other health plan.

Employee's Signature: _____ Date: _____/_____/_____

Revised 4/9/2015

HRA Claim Form

Claim Submission Guidelines

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do not consider cancelled checks as valid documentation.
- Previous balances are not acceptable.
- All reimbursements will be made payable to the employee.

Send completed claims via fax or mail to P&A Group.

FAX: Toll-free (877) 855-7105 or (716) 855-7105
MAIL: Flex Department
17 Court Street, Suite 500
Buffalo, NY 14202-3204

P&A Group Customer Service Information

Customer service representatives are available Monday - Friday, 8:30 AM - 10:00 PM ET.

WEBSITE: www.padmin.com
TOLL-FREE: (800) 688-2611

Electronic Claim Submission

Upload and submit your claims directly to the P&A website from your mobile device or computer. Log into your P&A account for more information.