# HRA Program Claim Form

**Iron Workers District Council of Philadelphia and Vicinity Health Benefit Plan**
**1807 Spring Garden St., Philadelphia, PA 19130**
**215-537-0900 or 800-473-5005 www.iwdcpa.com**

Please complete all applicable spaces. Please keep a copy of each claim for your records. For information regarding eligible medical expenses and dependents, please refer to IRS Publication 502 Medical and Dental Expenses.

## MEMBER INFORMATION

Member Name:
(First Name, Middle Initial, Last Name )

SSN Last 4: XXX-XX-

Member Home Address - Street:

| City: | State: | Zip Code: |
|---|---|---|
| Date of Birth: | Cell Phone: | Email: |

## QUALIFIED HEALTH CARE EXPENSES

| Date(s) of Service | Health Care Provider | Description of Expense | Patient Name | Relationship to Member | Amount Requested for Reimbursement |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | **TOTAL** | $ |

**To be reimbursed for eligible health care expenses, you must file a claim with the Plan Office. <u>This claim form must be accompanied by written proof from an independent third party showing that the medical care expenses have been incurred, the amounts of the expenses, and proof of payment</u>. Acceptable proof includes a copy of the Explanation of Benefits or a copy of the original claim form along with a paid statement. A statement or bill from a provider is not generally considered acceptable and will usually require additional documentation to constitute adequate proof of a claim.**

Please refer to the Plan's Summary Plan Description and Privacy Notice for information about how the Plan uses your health information for treatment, payment, and health care operations purposes.

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under the Plan's HRA Program and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I understand that I am fully responsible for the accuracy of all information relating to this claim. A claim will only be processed with a completed and signed claim form and correct documentation. I acknowledge that the Plan Administrator shall pay or reimburse approved expenses from the appropriate account up to the account balance. I certify that the dependents for whom I am submitting claims are eligible dependents under the Plan.

**Member Signature** **Date**

The Plan Administrator reserve the right to verify to their satisfaction all claimed expenses prior to reimbursement and to refuse any amounts that are not Qualified Health Care Expense.