HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

Please submit the completed, signed form to
SIGNIFICA BENEFIT SERVICES, INC.
PO BOX 7777, Lancaster, PA 17604-7777
PHONE: 717-581-1300 or 800-433-3746
For secure submission of claims with PHI, go to:
www.significabenefits.com\members
select "Submit Secure Email or Attachment"
FAX: 717-581-8379
www.significabenefits.com

1. Employer Name:		
2. Employee Name:		
3. Member Number (or) Last 4 Numbers of SS#:		
4. Email Address:		
5. Home Address:		
City:	State:	Zip:

To request reimbursement, please complete this form, include appropriate documentation and provide signatures where required. **All required fields applicable to your claim must be completed in order to process the claim.**

I certify that listed expenses have not been reimbursed by any other source, nor will they be reimbursed by any other source including but not limited to my health insurance. In addition, I certify that these expenses were incurred for eligible members of my family or me.

REQUIRED – CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

Participant's Signature _____ Date _____

HEALTH REIMBURSEMENT ARRANGEMENT - (REQUIRED – COMPLETE ALL SECTIONS)

In order to receive reimbursement, copies of supporting documentation must be attached. Please include copies of an itemized bill from the provider listing exact dates of service (balance forward statements are not acceptable), service performed, charge and TIN# and an Explanation of Benefits (EOB) from your insurance company listing service dates, service performed and cost. Please retain a copy of this claim form and supporting documentation for your records, as we are unable to return original documents to you.

PATIENT NAME	SERVICE DATE	DESCRIPTION	AMOUNT	PAY TO: ❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER
			$	❒ PROVIDER ❒ MEMBER