Health Reimbursement Account Reimbursement Request Form

Instructions: Please print or type and complete al items under Personal Information. In order to receive reimbursement, you must submit an Explanation of Benefits Statement (EOB) if applicable from your health insurance carrier or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable) and patient responsibility for each health care claim. You must sign and date this form and attach any corresponding receipts in order for us to process the claim. You have permission to photocopy this form.

Personal Information

Employer's Name	Email Address
Employee's Name	Date of Request
Employee's Social Security Number	Daytime Phone Number

Health Care Expenses

Patient Name	Relationship	Age	Date of Service	Type of Service	Requested Amount

(If more space is needed, please copy this claim form or attach additional pages)

Total: $_____

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Health Reimbursement Account, nor are reimbursable from any other source. I hereby authorize Alliance Insurance Group to obtain necessary information needed to process the claim. I understand my claim will be reimbursed based on the plan design for my employer.

Employee Signature:_____ Date: _____

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