HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

INSTRUCTIONS

Send completed, signed form with all supporting documentation to:

Email: SpendingAccountProcessing_Receipts@alegeus.com

or

Fax: (855) 898-2715

or

Mail:
Spending Account Processing
PO Box 162177
Altamonte Springs, FL 32716

If you have any questions, contact your Member Advocate Team number located on the back of the Member ID Card.

Please Note: Your Member ID number can be found on the front of your Member ID Card.

EMPLOYEE INFORMATION *(*required fields)*

*Name:	*Member ID:
Address:	City, State Zip:
Email:	*Phone:

UNREIMBURSED HRA EXPENSES *(attach supporting documentation)*

Does your receipt include all of the following?
- Provider's name & address - Service description - Date of service - Patient's name - Amount billed

******CREDIT CARD RECEIPTS ARE NOT ACCEPTABLE******

Person for Whom Expense Was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total Unreimbursed HRA Expenses	$

PARTICIPANT AGREEMENT *(*required fields)*

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

*Participant Signature

Date Signed