Benetech
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Health Reimbursement Arrangement

MEDICAL EXPENSE RECOVERY FORM

See reverse for instructions regarding this form.

EMPLOYER (COMPANY) NAME AND ADDRESS: Bethlehem Central School District
700 Delaware Avenue, Delmar, NY 12054

EMPLOYEE NAME: _____ EMPLOYEE ID# _____

ADDRESS: _____
(street) (city) (state) (zip)

☐ If new address check here

PATIENT(S) NAME(S)	RELATIONSHIP TO EMPLOYEE
	☐ CHILD ☐ SPOUSE ☐ SELF ☐ OTHER
	☐ CHILD ☐ SPOUSE ☐ SELF ☐ OTHER
	☐ CHILD ☐ SPOUSE ☐ SELF ☐ OTHER

When submitting this form you must complete the information requested and attach an ITEMIZED RECEIPT or an EXPLANATION OF BENEFITS from your insurance carrier.

DATES OF SERVICE	NAME OF PROVIDER	TOTAL OF AMOUNTS REQUESTED FOR REIMBURSEMENT

By signing and submitting this form you acknowledge that all requirements of Section 213 of the IRS code, as well as the plan document of your employer, have been satisfied.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR ADMINISTRATOR FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE _____ DATE _____

NOTE: THIS FORM SHOULD NOT BE USED FOR SECTION 125 PLAN CLAIMS.

I hereby certify that any amounts reimbursed to me under this Plan:

1. will not be claimed as a deduction on my personal income tax return; and,
2. will not be reimbursed to me by other health plan coverage, including a Healthcare Flexible Spending Account (Healthcare FSA) or Health Savings Account (HSA) plan

HRA INSTRUCTIONS:

Instructions for completing the HRA claim form:

- The Employer is the name of your company.
- Enter the Employee (your) name, the Employee ID Number (which is the last four digits of your Social Security Number), and the Employee Address.
- Check the box if this is a new address.
- List the patient(s) name(s) and relationship(s) to the employee. The entire family may be submitted on one claim form.
- List earliest date of service through the last date being submitted. For example: (6/5/07-6/16/07). List the name(s) of the provider(s). Indicate the grand total requested for reimbursement.
- **Signature is required,** as indicated by the bold arrows. Please date the form where appropriate.

This claim form and receipts may be submitted via mail, fax, or e-mail (flexinfo@benetech.cc).