

# HEALTH CARE REIMBURSEMENT ACCOUNT FORM

## ASEA Health Trust

Address: 111 W. Cataldo, Suite 220, Spokane, WA 99201 • Phone: 866-553-8206 (toll-free); 509-328-0300 • Fax: 509-328-8623

Website: [www.aseahealth.org](http://www.aseahealth.org)

Use this form to request reimbursement for eligible expenses from your Health Care Reimbursement Account.

### 1. Complete Sections 1-3

2. Submit the following supporting documentation with this request:

- Explanation of Benefits (EOB) statement must be submitted if claim is covered but not paid by any plan (for example, the amount you must pay out-of-pocket because of deductibles or coinsurance.)
- Copy of the copayment receipt from the provider when the copayment is your only cost and you do not receive an explanation of benefits statement (EOB).
- Itemized bills or receipts from the doctor, dentist, or other supplier for expenses **not covered** by your medical/dental plan(s).
- Documentation must include: Provider's name and address, patient's name, date(s) of service, description of service or

supply, and amount charged. **A cancelled check is not adequate documentation.**

3. For fastest processing and reimbursement, you should securely submit this form and all required supporting documentation to Contact Us on the Trust website ([aseahealth.org](http://aseahealth.org)). If you are unable to submit the form and documentation electronically, they may be mailed to: Zenith American Solutions, Attn: HCRA/HRA Team, P.O. Box 91082, Seattle, WA 98111.

4. If your claim submission is for more than three family members, please submit a separate claim form for the additional family members.

5. If you have questions about a health care reimbursement claim, call the ASEA Health Trust Administrator at the number above.

6. Send the completed benefit request form and documentation to the Administrator at the address above.

**Items for which you are reimbursed cannot be claimed as deductions or credits on your federal income tax returns.**

## 1. EMPLOYEE INFORMATION

Employee name:

SSN or Alternate ID:

Daytime phone number:

## 2. PATIENT INFORMATION

Name:

Date of birth:

Age:

Relationship to employee:  Self  Spouse  Child

Date(s) of service: From \_\_\_\_\_ through \_\_\_\_\_

Total Amount Submitted: \$ \_\_\_\_\_

Name:

Date of birth:

Age:

Relationship to employee:  Self  Spouse  Child

Date(s) of service: From \_\_\_\_\_ through \_\_\_\_\_

Total Amount Submitted: \$ \_\_\_\_\_

Name:

Date of birth:

Age:

Relationship to employee:  Self  Spouse  Child

Date(s) of service: From \_\_\_\_\_ through \_\_\_\_\_

Total Amount Submitted: \$ \_\_\_\_\_

## 3. CERTIFICATION

I certify that these expenses for which reimbursement is claimed from the Health Care Reimbursement Account have been incurred by me and/or my eligible dependents and are not payable by any other plans. I further declare that I have not and will not deduct these expenses on my federal, state, or local income taxes.

Employee signature:

Date:

Any person who knowingly and with intent to defraud or deceive any health plan, files a statement of claim containing any materially false, incomplete, or misleading information is guilty of a crime and may be liable for substantial civil penalties.