HEALTH REIMBURSEMENT ARRANGEMENT PLAN 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

1. Complete Sections 1–3 below for eligible expenses, incurred by you, your spouse, or other eligible dependents, for which you are requesting reimbursement under the HRA Plan.
2. Submit the following supporting documentation with this form:

- Explanation of Benefits (EOB) statement must be submitted if the claim is covered but not paid by any other plan. For example, the amount you must pay out-of-pocket because of the medical deductible or coinsurance.
- Itemized bills from your provider for eligible expenses not reimbursed by your health care plan or a Health Care Reimbursement Account. For example, dental and vision services that are not covered by the plan.
- Documentation must include: provider's name and address, patient's name, date(s) of service, description of service or supply and amount of charge. **A cancelled check or debit/credit card is not adequate documentation unless submitted with the other required documents.**

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). 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. Retain copies of your benefit request form and supporting documentation. Documentation submitted with this form will not be returned.
5. If you have questions about an HRA claim, call the ASEA Health Trust Administrator at the number 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 Reimbursement Arrangement Plan 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.