HEALTH CARE REIMBURSEMENT ACCOUNT FORM

ASEA Health Benefits Trust

Address: PO Box 91082, Seattle, WA 98111 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 866-528-7722 • Website: 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). 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: Not required if submitted on-line 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.

Save a Copy Print Close