HRA REIMBURSEMENT CLAIM FORM

EMPLOYEE NAME: _____

EMPLOYER NAME: _____ LAST 4 SS#: XXX-XX _____

PLEASE PRINT CLEARLY

PATIENT NAME	DOCTOR NAME / FACILITY NAME / PHARMACY NAME	SERVICE DATE / RX FILL DATE	TYPE OF SERVICE (MEDICAL, VISION, RX)	CLAIM AMOUNT
			Total:	**$**

ATTACH ALL EOB'S/STATEMENTS

By submitting this form to GMR Associates, Inc., I certify the information is accurate; the expenses incurred were for my spouse, qualified dependent(s) or myself. I certify that these expenses are not reimbursable under any other plan coverage. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

_____ _____

Signature of Employee Date