HRA / FSA REIMBURSEMENT CLAIM FORM

EMPLOYEE NAME: _____

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

PLEASE PRINT CLEARLY

PATIENT NAME	DOCTOR/FACILITY/ PHARMACY NAME	ACCOUNT (HRA, FSA, OR BOTH)	SERVICE/RX FILL DATE	TYPE OF SERVICE (MEDICAL, DENTAL, VISION, RX, OR OTC)	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 are 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