ALASKA TEAMSTER-EMPLOYER
WELFARE TRUST

Health Reimbursement Arrangement (HRA) Claim Form

(Please see the reverse side for instructions in preparing and submitting this form)

Completed forms should be sent to: Alaska Teamster-Employer Welfare Trust
520 E 34th Avenue, Suite 107
Anchorage, AK 99503

For questions regarding your account balance, the status of claim payments, eligible expenses or how to file a claim on-line, log onto the HRA portal or call the HRA customer service representative at **800-714-3209 – Prompts 2,1,2 or extension 1714.**

Participant Information (Please print legibly):

Name (Last, First, M.I.)	Last 4 of Social Security Number XXX-XX-
Address (Street, City, State, Zip)	Daytime Telephone

Allowable Medical Care Expense Information Please complete all of the information for each expense listed below. **You must also attach supporting documentation for each expense --> an itemized bill, Explanation of Benefits (EOB), and receipt(s). It is a good idea to make a copy of all materials you submit for your records.**

NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation.

The reimbursement form must be signed and dated as unsigned forms will not be processed.

**List each expense separately

Person for whom Expense was Incurred Relationship to Member	Date(s) Expense Incurred	Name of Service Provider	Expense Description	Reimbursement Amount Requested from HRA
				$
				$
				$
				$
				$
				$
			Total Reimbursement from HRA:	$

Certification:
I certify that my statements on this claim form are complete and true. I certify that any expenses reimbursed are for Allowable Medical Care Expenses for myself or my Dependent(s) and such expenses have not and will not be reimbursed by any other source or entity, nor be claimed as an income tax deduction.

_____ _____
Signature Date

Important Information

- You must sign and date this form
- Claims must be received by the Trust Office no later than 12 months from the date of service.
- If the claim is for prescribed over-the-counter medicine, you must submit one of the following items with your claim for reimbursement:
    - A receipt from a pharmacy which identifies the name of the purchase (or name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number; or
    - A receipt from a pharmacy without an Rx number accompanied by a copy of the related prescription.
- Keep copies of everything submitted
- If you have other insurance coverage that is secondary to this Plan, your claim must be filed with your secondary carrier before your claim for reimbursement is processed. You must submit a copy of the secondary carrier's Explanation of Benefits (EOB) with your claim for reimbursement.
- **<u>If you do not substantiate your claims, you will receive a 1099!</u>**