HRA Account

HEALTH REIMBURSEMENT
ACCOUNT REIMBURSEMENT
REQUEST FORM

Phone: 1-833-932-3912 **Fax: 1-866-514-8287**

A. EMPLOYEE INFORMATION

Name	Social Security Number (last 4 digits)	Name of Employer
Member ID	Phone Number	Email Address

B. HEALTH REIMBURSMENT ACCOUNT

Date(s) of Service	Name of Service Provider	Patient Name	Type of Expense (Office Visit, Dental, Eyeglass, RX, Co-Pay, etc.)	Amount Requested
			TOTAL AMOUNT REQUESTED	$

C. CERTIFICATION

I certify that the following is true:

- I will use my HRA to pay for IRS-qualified expenses, permitted under my Employer's HRA plans(s) provided to me and my IRS-eligible dependents, on the date(s) indicated above as being incurred within my period coverage.
- I have not and will not seek reimbursement for the medical expenses claimed on this HRA form through any other source. Prohibited sources include, but are not limited to, individual and group health insurance, HMO's, self-insured plans, etc.
- I will not claim any reimbursed HRA expenses for federal income tax deductions or credit, and will request reimbursement only after the services have been provided.
- I will collect and maintain sufficient documentation to substantiate my reimbursed HRA expenses to respond to any IRS or Employer inquiries I may receive.
- The eligibility of medical expenses under an HRA Plan is subject to IRS and FDA regulatory change at any time.
- I specifically release my Employer and Luminare Health from any liability resulting from either my participation in any HRA or for any misrepresentation I make regarding my HRA requests for reimbursement.
- Where improper reimbursement of ineligible HRA expenses has been made, the corrective procedure approved by the IRS and permitted under my Employers HRA plan will be followed.
- I have read and understand the information on the front of this form.

Employee Signature	Date

Luminare Health administers your HRA account. For your convenience, we've ensured you can access your account information by visiting your health plan's website: wellstarhealthplan.org.

Submit claims electronically by going to the My Benefit Spending Accounts link on wellstarhealthplan.org or by downloading the Benefit Spending Accounts mobile app.

You may also return this form to:
Benefits Spending Accounts
P. O. Box 2968, Clinton, IA 52733
Phone: 833-932-3912 Fax: 866-514-8287