Health Reimbursement Arrangement Claim Form

PREPARING YOUR CLAIM FORM

- Complete Sections 1 and 2.
- Complete Sections 3 and 4 as applicable. (Claims may be grouped by individual or listed separately.)
- Complete Section 5.
- Attach the appropriate documentation indicated below, which may include:
  - **Explanation Of Benefits (EOB)** – for expenses partially covered by your medical insurance plan. If insurance is available, you must submit your EOB with your completed claim form.
  - **Copay receipt** from the provider.
  - **Itemized bill or statement** from the provider when expenses are not covered by your medical plan, which includes:
    - Name & address of the provider
    - Patient's name
    - Dates of service
    - Type of service
    - Dollar amount charged
- ***Canceled check or credit card receipts are not adequate documentation.***

SUBMITTING YOUR CLAIM

- Retain copies for your files. Claim information cannot be returned.
- Send this completed claim form and documentation to:

  Aetna
  P.O. Box 3000
  Richmond, KY 40476-3000
  Fax to: 1-888-AET-FLEX

[Important Notes]
If you are submitting a claim with a change in your mailing address, you must notify your employer to make the change on your HRA enrollment file to avoid misdirected claim payments.

- Submit your Behavioral Health explanation of benefits for reimbursement consideration for eligible covered services.

1. Employer Information

Employer Name

HRA Control Number

2. Participant Information

Social Security Number – –

Name

Daytime Telephone Number ( )

Address (include ZIP code)

☐ Check if address is new

Evening Telephone Number ( )

3. Expense Information

Name _____ Relationship to Participant ☐ Self ☐ Spouse ☐ Child ☐ Other

Date(s) of Service (MM/DD/YYYY)
From _____ Thru _____ **Total Amount Submitted** $ _____

Name _____ Relationship to Participant ☐ Self ☐ Spouse ☐ Child ☐ Other

Date(s) of Service (MM/DD/YYYY)
From _____ Thru _____ **Total Amount Submitted** $ _____

Name _____ Relationship to Participant ☐ Self ☐ Spouse ☐ Child ☐ Other

Date(s) of Service (MM/DD/YYYY)
From _____ Thru _____ **Total Amount Submitted** $ _____

4. Coordination of Benefits (COB)

Are you or any family members for which you are requesting reimbursement eligible to receive benefits under any medical plan other than your primary coverage?

☐ Yes If yes, you must include a copy of your EOB. ☐ No If no, you must include an itemized statement.

5. Participant Certification

I certify that the information provided on this form is true and correct.

Sign Here ► **Participant Signature** _____ **Date** _____

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.
California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.
Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.
Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.