1605 Associates Drive
Suite 101
Dubuque, IA 52002
Phone: (563) 584-4853
Toll-free: 866-682-2993
Fax: (563) 556-5134
FlexProcessing@mahealthcare.com

HRA Claim Form

Employee:_____ Email Address:_____

Social Security # **or** Member #:_____

Employer:_____

For each of the accounts, please include documentation in the order you have listed and attach to this claim form.
NOTE: Cancelled Checks or credit card receipts/statements are not valid forms of documentation.

HRA

Dates of Service	Type of Expense	Dollar Amount to be reimbursed
		$
		$
		$
		$
		$
		$
		$
		$

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my reimbursement plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature: X_____ Date:_____