Upstate New York Engineers Health Fund

101 INTREPID LANE P.O. BOX 100 – COLVIN STATION
SYRACUSE, NEW YORK 13205-0100
PHONE # 315-492-1796

HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

Properly complete all fields in order to avoid a denial of your claim.

Section A- Member Information (please print)

☐ ✓ If new address

Members Name			Social Security Number
Street Address			
City	State	Zip	Daytime phone #

Section B- Claim Reimbursement Detail (please print)

- For Medical and/or Dental expenses you MUST provide a copy of your Explanation of Benefits Form.
- For Prescription Drug reimbursement you MUST provide an itemization from the pharmacy for multiple prescriptions (more then ten) or when submitting less then ten (10) please submit only one copy of the pharmacy receipt. Cash register receipts are not accepted.
- For Optical and Other reimbursements (Orthodontics, Lasik Surgery, insurance premiums, etc.), you must provide a paid receipt.
- Services listed must have been rendered and paid to qualify for reimbursement.

Please check type of benefit and include amount you are requesting for each.

	Amount Requested		**Amount Requested**
☐ **MEDICAL**	$ ______	☐ **DENTAL**	$ ______
☐ **OPTICAL**	$ ______	☐ **PRESCRIPTIONS**	$ ______
☐ **OTHER**	______		$ ______

TOTAL REQUESTED $ ______

*If you, your spouse or dependent children are enrolled in another health insurance plan in addition to or other than Upstate New York Engineers Health Fund, please refer to the back page forl further instructions.

Self Pay Premiums- If you are enrolled in one or more of the Self Pay Buy-In Plans you may elect to have your premium deducted from your HRA. Please indicate the plan(s) in which you and your eligible dependents are enrolled in.

Voluntary Buy-In Plan	Retiree and Widowed Spouse Buy-In Plan	Medicare Supplement Plan	C.O.B.R.A.	Other
☐Single ☐Family	☐Single ☐Family	☐Member ☐Spouse	☐Member ☐Spouse ☐Children	☐Member ☐Spouse ☐Children

Number of months you would like to deduct from your HRA.______

Note: The applicable monthly premium based on your election will be deducted from your HRA each month in which you are eligible for such coverage or until your HRA account no longer has a sufficient balance to cover the monthly premium or you cancel your election.

Section C- Member Signature

I certify that the expenses listed have been incurred by me and/or my eligible dependents and qualify for reimbursement. The expenses listed have not been reimbursed from any other insurance plan, including but not limited to another HRA, Health Spending Account or Flexible Spending Account. Expenses received from this HRA may not be applied towards Federal Income Tax deductions or credits.

Signature:	*Date:*

FUND OFFICE USE ONLY

AMOUNT REIMBURSED ______ *CHECK DATE* ______

Filing an HRA claim when enrolled in another health insurance plan.

If you, your spouse or your eligible dependents are enrolled in another insurance plan, please read and complete the following important information.

PRIOR TO SUBMITTING A CLAIM FOR REIMBURSEMENT FROM YOUR HRA YOU MUST SUBMIT ALL CLAIMS (MEDICAL, DENTAL, PRESCRIPTION AND OPTICAL) TO THE OTHER INSURANCE CARRIER PRIOR TO SUBMITTING A CLAIM FOR REIMBURSEMENT FROM YOUR HRA. YOU MUST PROVIDE AN EXPLANTION OF BENEFITS FORM FROM THE OTHER INSURANCE CARRIER FOR EACH CLAIM IN WHICH YOU ARE SEEKING REIMBURSEMENT. THIS INFORMATION IS REQUIRED TO DETERMINE YOUR ACTUAL UNREIMBURSED EXPENSES.

PLEASE INDICATE TYPE OF COVERAGE:

Medical ☐ Dental ☐ Prescriptions ☐ Optical ☐

Individuals covered: Member ☐ Spouse ☐ Dependent Child ☐ or Family ☐

OTHER INSURANCE INFORMATION:

Insurance Carrier ________________________________ Policy or Group # __________

Telephone number ____________________

Effective date: __________ **Termination date** (if applicable) __________

Claim Submission Tips

- Complete the form entirely and include member's signature. Only one benefit request form is needed when submitting multiple items.
- Submit only legible copies of documents. Bills or explanation of benefits (EOB) must include patient name, date(s) of service, provider name, and an itemization of charges. Balance forward, collection notices, cash register receipts are not acceptable.
- If the (EOB) contains services not covered by your insurance plan, include an itemized statement from your provider describing the service or items you are submitting for reimbursement.
- For any dental balances over $100.00 please send verification from the dental office that balance charged is the same as indicated on the EOB
- For prescription requests, please submit an itemized summary printout from your pharmacies for multiple prescriptions or when submitting for an extended time period.
- Paid receipts must be included for all optical and orthodontic expenses.
- If submitting health insurance premiums deducted from payroll, only those premiums deducted "after taxes" can be considered.
- The minimum reimbursement is $25.00.
- Mail completed form and documentation to:

Upstate New York Engineers Benefit Funds
101 Intrepid Lane
Syracuse NY 13205
Attn: HRA Dept.