HEALTH ECONOMICS GROUP, INC.

2101HR

NEWARK SCHOOL DISTRICT
HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

Please read these instructions before completing the claim form:

1. Employee must complete Part I and Part II.
2. Instructions for Part II "Health Care Expenses":
   A. Expenses covered by your spouse's or your health care plan(s) must be submitted to that/those plan(s) prior to submission to your health reimbursement account. You MUST attach a copy of the explanation of benefits (EOB) statement and/or an itemized bill showing health care plan(s) payment(s) in order to claim your patient responsibility amounts.
   B. For all other eligible health care expenses, attach an itemized receipt that clearly states the name and address of the provider, date of service, service rendered, name of person receiving the service and the amount charged. For over-the-counter (OTC) items, please attach a copy of your prescription or letter of medical necessity.
3. Read the Employee Statement, sign and date the form.
4. Mail (or fax) the completed form to the address (or fax number) provided on this form. Be sure that EOB's and/or itemized receipts are attached.
5. Claims will be submitted quarterly to the plan administrator.

Part I: Employee Information (Please Print)

Employee Name:		Last 4 Digits of Social Security Number:			
Address:					New Address? ☐ YES ☐ NO
Daytime Phone	Evening Phone	EMAIL:			

Part II: Medical Expenses (Please Print)

Covered Person	Date of Service	Provider	Type of Service Please check the appropriate box for each expense(s) MD=medical RX=prescription VS=vision DN=dental OT=other	Amount Claimed	Admin. Use
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
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			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			Medical Expenses Subtotal	$	

Total Amount Claimed	$

Employee Statement:

I request payment from my Health Reimbursement Account for the expenses itemized on this claim form. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I further certify that I have met all requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature: ______________________ Date: ______________

Send completed claim form to:

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Fairport, NY 14450
www.heginc.com

(585) 241-9500, ext. 504
(800) 666-6690, ext. 504
FAX: (585) 241-9518