HRA Claim Form

Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

Notice
All over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulations

1 Personal Information

Employee Name (First Name, Last Name) _____ Company Name _____

Street Address _____ City _____ State _____ Zip Code _____ ☐No ☐Yes Address Change?

Phone Number _____ Social Security Number _____

2 HRA Claims

	Date of Service MM	DD	YY	Provider	Service Rendered	Person Receiving Service	Amount
1							
2							
3							
4							
5							
6							
7							
8							
9							

Total Health Care Expense _____

3 Eligible Expenses

Please see your current SPD for a summary of your benefit

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____

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