



## HRA Reimbursement Form

### Claim Filing & Documentation Instructions

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| <p>1) Please sign claim form, include your email address and provide complete documentation for requested information. <b><u>Faxed claims received on Tuesday, will be reimbursed on Thursday.</u></b></p> <p>2) Attach an Explanation of Benefits (EOB) or itemized bill from the provider showing the provider name, expense description, date of service, amount paid. <b><u>Credit card receipts, cancelled checks, and cash register receipts are only acceptable for over the counter items.</u></b></p> <p>3) <b>Please note all Medical/RX claims must be submitted to your insurance provider first.</b></p> | <p>4) Submit pharmacy receipts showing date of service, prescription (Rx) name and number and total amount.</p> <p>5) Please send only copies and keep originals for your records.</p> <p>6) Fax Claims to: 301-564-5192<br/>Mail Claims to: 13511 Label Lane<br/>Suite 201<br/>Hagerstown, MD 21740</p> |
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Company Name _____	Check ONE (REQUIRED): <input type="checkbox"/> NEW claim <input type="checkbox"/> Resubmitted claim <input type="checkbox"/> Letter of medical necessity on file
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Employee Name _____	Daytime Phone Number _____	Social Security Number (Last 4 Digits) _____
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Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Check here if this a new address:  Email Address \_\_\_\_\_

### (Enter the following information for EACH attached receipt.)

Account Type (HRA)	Dates of Service (from / to)	Reimbursement Amount Requested	Provider Name	Type of Service or Prescription (Rx) Number	Family Member Name, if applicable
<b>ENTER TOTAL:</b>					

<b>Employee Certification</b>	I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents and are not payable by any other plan and will not be deducted on my federal, state or local income tax returns.		
	<table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 70%;"><b>Employee Signature (REQUIRED)</b></td> <td style="border: none; width: 30%;"><b>DATE</b></td> </tr> </table>	<b>Employee Signature (REQUIRED)</b>	<b>DATE</b>
<b>Employee Signature (REQUIRED)</b>	<b>DATE</b>		

**Fax or mail claims to BlueFund Administration, 13511 Label Lane • Suite 201 • Hagerstown, MD 21740  
Phone 866-208-8587 Fax 301.564.5192(DC METRO)**

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