

# 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 in blue or black ink when using this form
- Please allow 2 business days for claims to be processed

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

## 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			Provider	Service Rendered	Person Receiving Service	Amount
	MM	DD	YY				
1	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____	_____	_____
<b>Total Health Care Expense</b>							_____

## 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 \_\_\_\_\_