



HRA Provider Pay Form

Full Name: _____ Social Security Number: _____ Date of Birth: _____

Change of Address | Home Address: _____

Email: _____ Employer Name: _____

Medical Care Expense #1 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred: _____ Expense Description: _____

Person for Whom Expense Incurred: _____ Amount: _____

Name of Service Provider (make check payable to): _____ Patient Account # _____

Provider Address (Street/City/State/Zip): _____

Medical Care Expense #2 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred: _____ Expense Description: _____

Person for Whom Expense Incurred: _____ Amount: _____

Name of Service Provider (make check payable to): _____ Patient Account # _____

Provider Address (Street/City/State/Zip): _____

Medical Care Expense #3 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred: _____ Expense Description: _____

Person for Whom Expense Incurred: _____ Amount: _____

Name of Service Provider (make check payable to): _____ Patient Account # _____

Provider Address (Street/City/State/Zip): _____

All plan communication pertaining to your account activity is provided solely via email and the www.NueSynergy.com website. It is important to notify NueSynergy if you change your email address

I certify that all expenses for which payment is claimed by submission of this form were incurred during a period while I was covered under the Medical Expense Reimbursement Plan. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided. I hereby authorize the medical providers (hereafter Providers) listed above to accept and credit amounts received from NueSynergy to my account. In the event that NueSynergy sends funds erroneously to Providers, I understand that I must collect payment for an amount not to exceed the original amount of the erroneous credit and submit to NueSynergy. I understand that I am responsible for confirming my payment has been properly sent to Providers. Any resulting charges that occur because I have failed to abide by this will be my responsibility.

Employee Signature: _____ Date: _____

Fax, mail, or email completed forms and copies of bills, receipts to:

NueSynergy, Inc.
 4601 College Blvd, Suite 280, Leawood, KS 66211
 Phone: 913.653.8381 · Toll-Free: 855.890.7239 · Fax: 855.890.7238 · Email: customerservice@NueSynergy.com

For office use only: Date processed: _____ Amount Approved: _____ Amount Rejected: _____ Reviewed by: _____