



## HRA Participant Claim Reimbursement 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: \_\_\_\_\_ Amount: \_\_\_\_\_

Name of Service Provider: \_\_\_\_\_ Person for Whom Expense Incurred: \_\_\_\_\_

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

Date Incurred: \_\_\_\_\_ Expense Description: \_\_\_\_\_ Amount: \_\_\_\_\_

Name of Service Provider: \_\_\_\_\_ Person for Whom Expense Incurred: \_\_\_\_\_

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

Date Incurred: \_\_\_\_\_ Expense Description: \_\_\_\_\_ Amount: \_\_\_\_\_

Name of Service Provider: \_\_\_\_\_ Person for Whom Expense Incurred: \_\_\_\_\_

**Medical Care Expense #4 (A Copy of Your Explanation of Benefits is Also Required)**

Date Incurred: \_\_\_\_\_ Expense Description: \_\_\_\_\_ Amount: \_\_\_\_\_

Name of Service Provider: \_\_\_\_\_ Person for Whom Expense Incurred: \_\_\_\_\_

**Medical Care Expense #5 (A Copy of Your Explanation of Benefits is Also Required)**

Date Incurred: \_\_\_\_\_ Expense Description: \_\_\_\_\_ Amount: \_\_\_\_\_

Name of Service Provider: \_\_\_\_\_ Person for Whom Expense Incurred: \_\_\_\_\_

**\*\*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\*\***

The undersigned participant certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Medical Expense Reimbursement Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax or mail 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

**For office use only:** Date processed: \_\_\_\_\_ Amount Approved: \_\_\_\_\_ Amount Rejected: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

