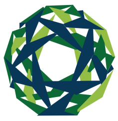

NueSynergy

CUSTOMER FOCUSED & TECHNOLOGY DRIVEN

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 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:__________