QualChoice® HEALTH INSURANCE

HRA Claim Form

Proof of expenses must be attached. Bills, statements, or *Explanation of Benefits (EOB)* from medical plans are required proof of expenses.
IMPORTANT! Cancelled checks and credit card receipts are not sufficient proof of expenses.

Section 1: Employee Information. Please print legibly.				
Full Name		QualChoice ID No.		Social Security No.
Street Address	City	State	Zip	Phone No.

Health Care Expenses

Please only report one (1) expense per block. Combining multiple expenses in one block may delay reimbursement. If expense was incurred for eligible dependent, indicate type of relationship. Use "C" for child, "S" for spouse or "O" for other.

Date of Service: (MM/DD/YYYY)	Type of Service: ☐Dental ☐Health ☐Vision ☐Prescription	Amount: $
Name of Provider/Merchant:		
Dependent Name:	Relationship to Employee:	Date of Birth: (MM/DD/YYYY)

Date of Service: (MM/DD/YYYY)	Type of Service: ☐ Dental ☐ Health ☐ Vision ☐ Prescription	Amount: $
Name of Provider/Merchant:		
Dependent Name:	Relationship to Employee:	Date of Birth: (MM/DD/YYYY)

Date of Service: (MM/DD/YYYY)	Type of Service: ☐ Dental ☐ Health ☐ Vision ☐ Prescription	Amount: $
Name of Provider/Merchant:		
Dependent Name:	Relationship to Employee:	Date of Birth: (MM/DD/YYYY)

Date of Service: (MM/DD/YYYY)	Type of Service: ☐ Dental ☐ Health ☐ Vision ☐ Prescription	Amount: $
Name of Provider/Merchant:		
Dependent Name:	Relationship to Employee:	Date of Birth: (MM/DD/YYYY)

Date of Service: (MM/DD/YYYY)	Type of Service: ☐ Dental ☐ Health ☐ Vision ☐ Prescription	Amount: $
Name of Provider/Merchant:		
Dependent Name:	Relationship to Employee:	Date of Birth: (MM/DD/YYYY)

Date of Service: (MM/DD/YYYY)	Type of Service: ☐ Dental ☐ Health ☐ Vision ☐ Prescription	Amount: $
Name of Provider/Merchant:		
Dependent Name:	Relationship to Employee:	Date of Birth: (MM/DD/YYYY)

SECTION II. Authorized Signature

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. I further certify that if the above expenses are not eligible, I will remit payment in the amount of the ineligible expense to the plan. Additionally, these expenses are not being claimed as tax deductions under the IRS code.

Employee Signature X	Date Signed (MM/DD/YYYY)

Mail: QualChoice, ATTN: HRA Dept., P.O. Box 25610, Little Rock AR 72221 or Fax: 833.765.1963