Request for HRA Reimbursement CLAIM FORM

Lucent Health
P.O. Box 7020
Appleton, WI 54912-7020

Phone: 877-236-0844
Fax: 920-968-4616
Web: Lucent.wealthcareportal.com

Employer Name_____ **Employer Group #**_____

	Last:	First:	MI	SS#:	

☐ Please check if this is a new address

	Street:	City:	State:	Phone:	

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim. All information below must be completed.

Medical Expense Claims

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
					$
					$
					$
					$
					$
					$
					$
					Total:

Please attach copies of all receipts to this claim form. For medical/dental expense claims that were submitted to a medical plan or an insurance company but not paid by that carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefits forms) to establish amounts not covered under the medical/dental plan.

For all other reimbursable expenses, copies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Canceled checks are not acceptable receipts.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT
I certify that the expenses for reimbursement requested from my account was incurred by me (and/or my spouse and/or eligible dependents), will not be reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my employer's Health Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ *Date:* _____ / _____ / _____

Once complete, please mail to ***Lucent Health*** *at P.O. Box 7020, Appleton, WI 54912-7020; or fax to 920-968-4616.*
(Retain a copy for your records.)