HEALTH REIMBURSEMENT ACCOUNT

HRA **RX ONLY** REIMBURSEMENT CLAIM FORM

EMPLOYEE INFORMATION

Employer: _____ SSN or ID #: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number(s) Mobile: _____ Other: _____

Email: _____

HEALTH REIMBURSEMENT ACCOUNT (HRA) RX CLAIM INFORMATION

Claim	Name of Member	Relation to Employee	Date(s) of Service	Provider	Description	Amount Paid by You
1						
2						
3						
4						
5						
6						
Total HRA RX Claims Reimbursement						

I certify that the expenses for which reimbursement is requested under my employer's HRA Plan were incurred by myself or my eligible dependents, and that these expenses were incurred within the plan year period of my election. I also certify that the incurred expenses have not been reimbursed, and that I will not seek reimbursement, under any other plan covering health benefits. The expenses are for qualifying pharmacy/rx items. I will not use expenses reimbursed through my employer's HRA Plan as deductions when filing my income tax return. I authorize BRMS to issue the amount requested above from my employer's Cafeteria Plan account in accordance with the terms and provisions of the Plan.

Employee Signature: _____ Date: _____

FORM SUBMISSION & QUESTIONS

PHONE: (888) 326-2555

EMAIL: BRMS-FSA@brmsonline.com

SECURE FAX: (866) 410-0880

MAIL: BRMS-Flex
PO Box 1697
Folsom, CA 95763