This Claim Form serves as the cover page.	**Complete when faxing:** # of pages: _____ Daytime phone # _____

MOUNTAIN STATES
ADMINISTRATIVE SERVICES

Health Reimbursement Account (HRA) Claim Form

EMPLOYER:	DATE OF CLAIM
NAME OF EMPLOYEE: FIRST MI LAST	ALTERNATE ID #
ADDRESS: STREET CITY STATE ZIP CODE	DAYTIME PHONE #

Expense Information (please print)

Complete the following information for each claim expense item. Attach supporting **EOB** documentation for each expense. The claim form and documentation must list the date(s) that the service was performed, provider name, type of service, patient name, and your portion of the charge for the service.

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
			Total Requested Reimbursement Amount	$

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HRA to be reduced by the amount requested.

Signature: *X*_____ Date:_____

Submitting your HRA Claim

Provide an EOB for all expenses submitted.

You must complete all sections above. Failure to complete all sections of this form or to attach supporting EOB documentation will delay your reimbursement.

Sign and date the Claim Form.

Send HRA Claim Form and supporting EOB documentation to Mountain States Administrative Services:
EMAIL: fsa@mymsas.com
FAX: 520-722-7127
Mailing Address: Mountain States Administrative Services – 7202 E Rosewood – Suite 200 – Tucson, AZ 85710