###3T01802##################

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

INSTRUCTIONS

Send completed, signed form with all supporting documentation to:

Email: SpendingAccountProcessing_Reciepts@alegeus.com *or* **Fax:** (855) 898-2715 *or* **Mail:** Spending Account Processing PO Box 162177 Altamonte Springs, Florida 32716

If you have any questions, contact your Member Advocate Team number located on the back of the Member ID Card.

EMPLOYEE INFORMATION *(*required fields)*

*Name:	*SSN:
Address:	City, State Zip:
Email:	*Phone:

UNREIMBURSED HRA EXPENSES *(attach supporting documentation)*

Does your receipt include all of the following?

- Provider's name & address - Service description - Date of service - Patient's name - Amount billed

******CREDIT CARD RECEIPTS ARE NOT ACCEPTABLE******

Person for Whom Expense Was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total Unreimbursed HRA Expenses	**$**