



## HRA Reimbursement Form

Employer: \_\_\_\_\_

Employee Name \_\_\_\_\_ SS# \_\_\_\_\_

<p><b>PLEASE READ CAREFULLY</b></p> <p>These rules apply to all reimbursement requests</p>	<ol style="list-style-type: none"> <li>1. An Explanation of Benefits (EOB) from your health plan is required.</li> <li>2. One claim form can be used for a combination of family members and/or expenses.</li> <li>3. Reimbursement will be made only to the individual employee.</li> <li>4. Separate claim forms must be completed for expenses incurred in different calendar years.</li> <li>5. This form must be completed, signed, dated and mailed or faxed to FSAI along with EOB.</li> </ol>
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### Healthcare Expense Claims Applied to Deductible

Patient Name	Date Expense Incurred	Name of Provider or Merchant	Charge Applied to Deductible
Total Charges Applied to Health Care Deductible			

I certify that these expenses for which reimbursement is claimed from my HRA account have been incurred to me and/or my eligible dependents during the applicable plan year.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Submit completed forms and documentation to:**

First Service Administrators, Inc. • 3035 Lakeland Hills Blvd • Lakeland, Florida 33805-2225  
 Fax Number: 863.577.8039 • Email Address: flex.admin@myfsai.com

**\*Access your account 24/7 at [www.online-enrollment.com/FI1st](http://www.online-enrollment.com/FI1st)\***