Health Reimbursement Arrangement

BRICKLAYERS AND ALLIED CRAFTWORKERS
HEALTH CARE PLAN HRA ACCOUNT
P. O. Box 1607
San Ramon, CA 94583
(888)208-0250

Instructions: To receive benefits from the Healthcare Reimbursement Account (HRA), you must complete **ONE FORM** per patient, along with the following information:

Reimbursement for:	**Information Required:**
Medical Co-payments	Copy of your Explanation of Benefits Form (EOB). **Balance due statements are not acceptable.**
Dental Co-payments	Copy of your Explanation of Benefits Form (EOB). **Orthodontic services will be paid for after services are rendered.**
Vision Co-payment	Copy of your Explanation of Benefits Form (EOB). **All vision services MUST be submitted through your vision benefit plan, prior to submitting through your HRA account.**
Prescription Co-payment	Medications only prescribed by a doctor or insulin. Copy of the printout from your pharmacy. **Cash register receipts are not acceptable.**

PLEASE NOTE: You MUST allow up to 30 business days for reimbursement. All reimbursements for claims will be made payable to the member.

Member's Name: _____ Member's SS#: _____

Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Name: _____ Relationship: _____

Type of Service (Medical, Dental, Vision or Prescription)	**Providers Name**	**Date of Service**	**Amount of Claim**
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

By signing this form, I understand that benefits shall be paid in accordance with the Healthcare Reimbursement Account Plan eligibility requirements and limitations established by the Board of Trustees. (See reverse side of this form for a brief description of covered benefits).

Member's Signature: _____ Date: _____