EWBTF
Electrical Workers Benefit Trust Fund

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1828 North Meridian Street – Suite 103, Indianapolis, IN 46202

HEALTH REIMBURSEMENT ACCOUNT
CLAIM FORM

Participant Name:		**SSN:**	
Address:		**Phone:**	
City:		**State:**	**Zip:**
I would like payment to be made to (circle one):			
Provider		**Member**	
Patient's Name	**Date of Service**	**Description**	**Amount**
		Total	

Requirements for filing an HRA claim

1. Timely filing – Six months from the date of service (not the date of payment)
2. Itemized bill – must show patient's name and date of service
    a. If you do not have an itemized bill, you can use an Explanation of Benefits (EOB) from our office along with proof of payment that matches the EOB.
3. Proof of Payment- required when reimbursing member
4. Insurance Payment – Claims must be processed through all insurance first
5. Receipt of Payment – Allow 10 to 15 days for reimbursement
6. Claims Processor – Last names A-M can be emailed to lduke@ewbtf.org
   Last names N-Z can be emailed to kfunk@ewbtf.org

Failure to complete the entire HRA claim form by following the steps above <u>WILL</u> delay payment and may result in your claims getting mailed back to you.

I authorize the deduction from my Health Reimbursement Account (HRA) for the claims(s) listed above. I understand the Benefit Office does not reimburse for warranties and/or any fees associated in collection of a payment.

Signature:	**Date:**