

## HRA CLAIM FORM

Participant Name:		Member ID/SSN:
Email Address:		Phone:
Address:		
City:	State:	Zip:

I would like to pay to the (check one):				
Provider <input type="checkbox"/>			Member <input type="checkbox"/>	
Patient's Name	Date of Service	Description	Amount	For Internal Use Only
Total:				

### Requirements for Filing an HRA Claim

- Timely Filing:** Claims must be submitted within 12 months from the Date of Service (not the payment date).
- Itemized Bill:** Must include the patient's name, services performed, and date of service. If an itemized bill isn't available, submit the Explanation of Benefits (EOB) with proof of payment.
- Insurance Payment:** Claims must be processed through insurance first, no exceptions.
- Reimbursement:** Expect 10 to 15 business days for reimbursement.

### Expedite Processing

- Sign up for [HRA Auto Payment](#).
- Sign up for Direct Deposit.
- Ensure email images are at actual size or documents are in PDF format.
- Only submit one patient per form.
- Submission via Email: Send all documents to [hraclaims@ewbtf.org](mailto:hraclaims@ewbtf.org).

**Note:** Failure to follow these steps could result in delayed payments, and claims will be denied if incomplete.

### Authorization for Signature

I authorize the submission of my HRA claim and the release of necessary information.

I certify the information is accurate and complete. I understand this allows deductions from my HRA for the listed claims, and the Benefit Office does not cover warranties or collection fees.

Signature:	Date:
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