



Electrical Workers Fringe Benefit Administrative Office - IBEW 481
T 317.923.4577 | F 317.923.7633 | E hraclaims@ewbtf.org
1828 Meridian Street, Suite 103, Indianapolis, IN 46202

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

1. **Timely Filing:** Claims must be submitted within 12 months from the Date of Service (not the payment date).
2. **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.
3. **Insurance Payment:** Claims must be processed through insurance first, no exceptions.
4. **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.

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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