DRIVEN 125
BENEFIT ADMINISTRATORS

HRA REIMBURSEMENT REQUEST FORM

Internal use only: Forward this claim request to the Driven Benefit Administrators account management team.

Instructions: Please print or type and complete all items under **Personal Information**. In order to receive reimbursement, you must submit an *Explanation of Benefits Statement* (if applicable) from your insurance carrier, or an itemized statement that includes the provider name, patient name, date of service, description of service, insurance responsibility (if applicable), and patient responsibility for each health care claim You must sign and date this form and attach any corresponding receipts in order for us to process this claim. You have permission to photocopy this form.

PERSONAL INFORMATION	
Employer's Name	**Email Address**
Employee's Name	**Date of Request**
Employee's Social Security Number	**Daytime Phone Number**

HEALTH CARE EXPENSES					
Patient Name	**Relationship**	**Age**	**Date of Service**	**Type of Service (Medical, Dental, etc.)**	**Requested Amount**
1.					
2.					
3.					
4.					
5.					
6.					
				Total:	

I, the undersigned, hereby certify that the above listed expenses have not been previously reimbursed from my Health Reimbursement Account, nor are reimbursable from any other source. I hereby authorize Driven Benefit Administrators to obtain necessary information from all physicians, hospitals, employers and all other agents in order to adjudicate the claim for reimbursement under the Benefit Plan established by my employer.

Employee Signature **Date**

DRIVEN BENEFIT ADMINISTRATORS
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