JRM Benefit Administrators, LLC

Attn: Claims Department
PO Box 277
Onalaska, WI 54650
Phone: (608) 781-8712
Claims Fax: (608) 781-8713

HEALTH REIMBURSMENT ARRANGMENT (HRA) REIMBURSEMENT CLAIM FORM

⇨Reminder: *Read the instructions on the reverse side of the claim form before completing.*
To expedite your claim, please provide ALL appropriate information showing the date and description of service.

Social Security Number	**Daytime Phone Number**
Last Name	**First Name**
Employer Name	
Email Address	
☐ **Change of Address:**	

Are You a FSA Plan Participant?

☑ ***Check the Box that Applies to You***

☐ Use available FSA Plan balance for reimbursements on medical expenses not covered by the HRA Plan. If you have additional FSA claims you must use a FSA Form.

☐ Only use HRA Plan for Reimbursement

Unreimbursed Medical Expense Claims ➲ Services must be itemized. Do not lump line items together.

Date of Service	Name of Service Provider	Description of Service (Deductible, Vision, Dental, OTC, Rx)	Name of Covered Dependant	Relationship to Employee	Net Amount	Office Use Only

✓Attach appropriate receipt(s) and submit with this claim form.

Total HRA Claim:

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

***Employee Signature** is* **required** *to process this claim. Spouse or dependant cannot sign claim form.*

Employee's Signature _____ **Date** _____

Office Use Only

Date Received _____

Notes _____

Instructions and Helpful Hints

General Information

- Submit your completed claim form and attached documentation to: JRM Benefit Administrators, Attn: Claims Dept, PO Box 277, Onalaska, WI 54650 or fax to (608) 781-8713. When faxing please do not follow-up with a hard copy in the mail.
- If you have not received any correspondence (reimbursement check, direct deposit, letter, and/or email) or a telephone call from us after ten (10) days from submitting your claim please contact our office with questions at (608) 781-8712.

Employee Profile

- Please fill in *ALL* the requested information. Remember to print your information so we can process your claim accurately.

Website

- To access the Web site go to: www.repayme.com/admin/default.asp?cn=JJAI or www.jrmcpa.biz and select "links" on the left side of the screen and then select "JRM Benefit Administrators - participant login" from the list.
- For first time users follow these steps: At the login screen enter: "Login ID" (your social security number), "PIN" (last 4 digits of social security number), "Login Method Using" (select social security number). Note: with your first login, you will be prompted to change your PIN. After completing the questions and selecting "change PIN" you will be able to view your account and submit claims.
- When you are done viewing your account select "Logout".

Unreimbursed Medical Expense Claims

- Please fill in *ALL* of the fields. This information is required and must be filled in for your claim to be processed.
- Provide a copy of the Explanation of Benefits (EOB) from your insurance company for qualified expenses (if available).
- When attaching a copy of an itemized statement as proof for qualified expense, the itemized statement *must* contain the following information: **1.** name and address of the provider, **2.** patient's name, **3.** date of service (date service was provided, not the date service was paid for), **4.** description of services provided, and **5.** itemized charges.
- If you are submitting a claim for a prescription drug, the receipt provided by the pharmacist must be submitted which contains the following information: **1.** name of the provider, **2.** patient's name, **3.** date of service (date service was provided, not the date service was paid for), **4.** prescribing physician, and **5.** prescription dollar amount.
- Cancelled checks, credit card receipts, or statements detailing only a balance due **ARE NOT** considered acceptable documentation for reimbursement.
- Orthodontia claims require the following documentation: **1.** an itemized statement and **2.** the orthodontics' contract agreement showing the monthly payment.
- For qualified over-the-counter expenses, you must submit evidence of the purchase date and the specific medicine and/or drug name. **Vitamins, supplements, herbal remedies, and hygienic products are not qualified expenses and cannot be reimbursed through your FSA Plan.** If your physician diagnoses a specific medical condition and the product is medically necessary to treat that condition you may submit the product for reimbursement with a letter from your physician detailing the required explanations above.
- If faxing your claim, *do not highlight the medical expense* because the item is blacked out on the receiving fax.
- Do not highlight the medical expense on cash register receipts because the item becomes faded and/or blacked out.
- Please list each expense individually on the claim form, do not lump items together. Listing out each expense speeds up the claim processing procedure and you will receive your reimbursement sooner.
- Only submit copies of receipts, itemized statements, etc. You should keep all originals, including receipts for your personal records.

Employee Signature

- Be sure to sign and date this claim form before submitting it for reimbursement. We cannot process your claim with this part missing.
- The **employee** can only sign this claim form; spouse or dependant **CANNOT** sign this form.

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Your online account has everything you

Need to manage your HRA Plan