HRA REIMBURSEMENT REQUEST FORM

Complete the following for expenses incurred by you, your spouse, or eligible dependents. Be sure to complete all information requested on this form. Any missing information may result in a delay in processing your request. Please type or print the information. Remember to sign and date the form.

HRA	Group #	ID #
Group Name		
Employee Name		

Note – If you are submitting a claim for over the counter (OTC) drugs or medicines you must also provide a Letter of Medical Necessity (LMN), a copy of which may be found on our website at ***www.r1benefitstoday.org***.

Note – If your spouse has a Health Savings Account (HSA), please do not submit claims for your spouse.

Dates of Service	Person Receiving Services			Service Provider Name	Claim Amounts
___/____/___ To ___/____/___	Name -				$
	Myself ☐	Spouse ☐	Dependent ☐		
___/____/___ To ___/____/___	Name -				$
	Myself ☐	Spouse ☐	Dependent ☐		
___/____/___ To ___/____/___	Name -				$
	Myself ☐	Spouse ☐	Dependent ☐		
___/____/___ To ___/____/___	Name -				$
	Myself ☐	Spouse ☐	Dependent ☐		
___/____/___ To ___/____/___	Name -				$
	Myself ☐	Spouse ☐	Dependent ☐		
___/____/___ To ___/____/___	Name -				$
	Myself ☐	Spouse ☐	Dependent ☐		
				Reimbursement Request Total	$

By submitting this form, I certify that this is a valid claim for incurred eligible expenses as defined by the IRS, and the information provided is complete and accurate to the best of my knowledge. I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Region I, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement, and I will be liable for the payment of all related taxes and amounts paid from the Plan related to such expenses. I understand that the reimbursed expenses should not be claimed on my income tax return and I will retain a copy of all submitted documentation in the event of an IRS audit. I understand it is my responsibility to notify Region I of any changes in the information provided.

Signed _____ Date _____

Print two copies. One for you and send the other one to:

Reimbursement Plan
Region I
3031 17th St. S.
Moorhead, MN 56560

800-450-2990 or 218-236-2990 - Fax 218-236-2368
www.r1benefitstoday.org

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