BBP Admin
BENEFITS ADMINISTRATION
COBRA, FMLA, FSA, HRA, HSA, TRANSIT
info@bbpadmin.com
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630 773 2337

HRA DEDUCTIBLE REIMBURSEMENT CLAIM FORM

20____ Plan Year

Employer Name: _____

Name: _____
Last First Middle E-Mail Address or Phone Number

Please Print Address if Different from what is on file:_____

The HRA plan has been adopted to save premium dollars on the rising cost of medical insurance. Your employer has adopted a high deductible plan. Employees and dependents of will receive major medical benefits once the high deductible has been reached. In order to receive reimbursement for your deductible claims, you must 1st submit your claim to your insurance carrier if your doctor did not already do this task. Then complete this claim form and attach a copy of the Explanation of Benefits hereinafter "EOB" from your insurance carrier showing what portion of your claim was applied to the deductible.

HRA Deductible Reimbursement:

Calculate the Amount of Reimbursement you are Eligible for.

Enter the Deductible Amount Incurred on the EOB(s) that you are including with this Claim Form for which you are requesting reimbursement. Remember not to include deductible portions that you are responsible for paying.

= $_____
The Amount You Are to Be Reimbursed

REMEMBER You must attach a copy of your most recent insurance carrier Explanation of Benefits Statement indicating the actual expenses incurred and accepted by your insurance carrier showing what was applied to your in network deductible. Your plan year is 01/01 – 12/31 of each year. The last day to submit claims is 90 days following the close of the plan year. It is your responsibility to inform your plan administrator about ongoing or lost claims before the end of the 90 days.

I the undersigned participant in the plan certify that:

1) The attached claim was incurred during the plan year while I was an active participant in the group medical plan.
2) I am solely responsible for the sufficiency, accuracy & veracity of all the information relating to this claim.
3) I understand that after I have been reimbursed the maximum amount available to me, it is my responsibility to pay 100% of the remaining coinsurance limits that are applicable to the health plan.

_____ _____
Signature Date

Enter online or thru the mobile app, or mail, fax, email this completed Claim Form & Your Explanation of Benefits to:

BBPadmin
125 West Orchard Street
Itasca, IL 60143
Phone: 630-773-2337 | Fax: 630-775-8568 | Email: claims@bbpadmin.com