Submit your claim online

Claim Submittal Options

HRA Medicare Rx Claim Form

20___ Plan Year

Employer Name_____

Employee Name_____

Phone # or E-mail address_____

☐ Please check this box if your address on file with BBP Admin has changed. **New Home Address**_____

PAYMENT OR REIMBURSEMENT OF HRA MEDICARE RX CLAIMS ARE SUBJECT TO THE PROVISIONS OF YOUR EMPLOYER'S PLAN DOCUMENTS AND APPLICABLE LAWS AND REGULATIONS

All HRA Medicare Rx claims must be submitted with the "bag tag" or documentation that verifies the following: (1) Date of Service/Prescription Fill Date (2) Patient Name (3) Pharmacy Name (4) Cost of Rx. Store receipts only will not be accepted.

Date of Service/Prescription Fill Date	Patient Name	Pharmacy Name	Reimbursement Request Amount
			$
			$
			$
			$
			$
			$
			$
			$

TOTAL HRA MEDICARE RX EXPENSE REQUEST: $_____

Please keep your originals and email, fax, or mail copies of your bills or receipts for the health care expenses included on this form.

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Company's HRA Medicare Rx Plan with respect to such expenses and that the health care expenses, if applicable, have not been or are not reimbursable under any other health plan coverage. I, the undersigned, certify that a federally recognized dependent or I incurred these expenses and the expenses are eligible under federal law. **I fully understand that I alone am responsible for the sufficiency, accuracy, and truthfulness of all information relating to this request and that unless an expense for which payment or reimbursement is requested is an eligible expense under the plan and IRS law, I may be liable for payment of all related taxes including federal, state, and/or city income tax and penalties on amounts paid from the plan which relate to the taxation of ineligible expenses.** A copy or electronic copy of this form and all supporting documentation shall be deemed as valid as the original.
Furthermore, (1) IMPORTANT: If expenses are from different plan years, funds will be depleted form the older plan year first (2) Requests for the current plan year must be received by BBP Admin by the Runout date of our plan (3) claims can be submitted online at https://betterbusinessplanning.wealthcareportal.com, email claims@bbpadmin.com, faxed or mailed to our office (4) Documentation must include ALL of the following: Date of Service/Prescription Fill Date, Patient Name, Pharmacy Name, Cost of Rx.

X_____ _____

Plan Participant's Signature (You must sign this form to be reimbursed.) DATE

Claim Confirmation: You can easily view your claim status 24/7/365 by logging into the Participant Portal at https://betterbusinessplanning.wealthcareportal.com. Please allow 24-72 business hours for claims to be processed.