CLAIM FORM

Claim Form Filing & Documentation Instructions

Company Name: _____ ☐ New Claim ☐ Additional Information Requested

Employee Name: _____ Last four digits of Social Security Number: _____

E-Mail: _____ Phone Number: _____

Follow the Claim Reimbursement Instructions on the reverse side and submit proper documentation in order to expedite claims processing
****If you are submitting Debit Card verification, please use the Summit Card Substantiation Form available on our website****

Health Care Expenses

Date of Service	Account Type (FSA, HRA, Dental / Vision Reimbursement)	Provider Name	Type of Service or Prescription (Rx) Name/ Number	Participants or Family Member Name	Reimbursement Request Amount
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
				TOTAL	

Dependent Care Expenses

Name of Eligible Dependent(s)	Date(s) of Care		Name Address & Taxpayer Identification No (or Social Security No) of Service Provider	Amount Charged
	From	To		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
			Total Dependent Care Expenses	
Provider's Signature				

Employee Certification: I certify that these expenses for which reimbursement is claimed have been incurred by me and/or my eligible dependents. These expenses are not, and will not, be payable by any other plan, will not be reimbursed or discounted from any other source and will not be deducted on my federal, state or local income tax returns.

Employee Signature: _____ Date: _____

Submit Claim Form and Receipts:
Fax: (610) 774-9910 pg 1 of_____ (no cover page needed)
Summit Mobile App: Download the app, login to your Summit account, click on SnapClaim and follow the instructions
On-line claims Entry: Login to your Summit account, click on transactions and follow the instructions.
Mail:
Human Resource Administrators, Inc.,
1541 Alta Dr, Suite 306,
Whitehall, PA 18052

If you submit your claim online at www.hradministrators.com or with the Summit mobile app this form is not needed

HRAdministrators

Claim Reimbursement Instructions

1. **Complete** all company and employee information on the front page (please print/type).

2. **Health Care Expenses – Complete** all required information in the *Health Care Expense* portion of the claim form and **attach** supporting documentation. A copy of a receipt or Explanation of Benefit (EOB) must accompany the request for each claim submitted. **HRA reimbursement requires the EOB**.

   Please remember documentation should include the following:

   - ✓ Original date of service (not the date of payment)
   - ✓ Description of service performed (refer to Eligible/Ineligible list to identify valid services)
   - ✓ Provider's name and address
   - ✓ Name of person cared for
   - ✓ Amount charged to you (do not include amounts reimbursed by another source)
   - ✓ **Orthodontia** please visit our website for a sample worksheet and guidelines on how the reimbursement is calculated each plan year. You may submit the worksheet along with this claim form to seek reimbursement.
   - ✓ **For Prescription drugs** a Pharmacy script or mail order statement showing the date filled (not paid), prescription name, patient name and charged amount or itemized printout of prescriptions from the pharmacy. Cash register receipts alone are not acceptable.
   - ✓ **Over-the-Counter items** cash register receipt showing merchant name, date, product description, dollar amount, **and** if medicine a written prescription from the patients doctor.
     - ❖ Please note OTC medicines can be purchased "off the shelf" or dispensed through the pharmacy as you **would a regular prescription.**

   Canceled checks or credit card receipts are not accepted as adequate documentation.

3. **Dependent Care Expenses – Complete** all required information in the *Dependent Care Expense* portion of the claim form. Dependent Care expenses may only be reimbursed for the amount you have in your account at the time of your claim. If your claim is for more than the balance in your account, the rest of the claim will be paid as additional contributions are posted. **Have** the daycare provider sign the claim form –OR- **attach** supporting documentation. **Canceled checks or credit card receipts are not accepted as adequate documentation**. Please remember documentation should include the following:

   - ✓ Dates of care
   - ✓ Taxpayer Identification Number(EIN)-OR-Social Security Number of Service Provider
   - ✓ Name of person cared for
   - ✓ Amount charged for care – paid amounts are not acceptable

4. **You MUST sign and date** the 'Employee Certification' section on the front of this form.

Important Reminders

- ✓ Payments are issued after receipt and processing, subject to claim approval
- ✓ Only send copies of receipts, bills, etc. (keep your originals)
- ✓ Do NOT highlight any part of your receipt, bill, etc.
- ✓ Any items for which you are reimbursed cannot be claimed again as deductions or credits on your individual tax return at the end of the tax year.
- ✓ Payments will be made directly to you. Payments cannot be made to a provider or another person.
- ✓ Terminated employees may submit claims with a date of service incurred prior to termination date only for a specified duration of time as stated in your Summary Plan Description
- ✓ All claims received by Friday (5:00 EST) will be processed by the following Friday

For more Claim Forms or to register your Summit account, visit www.hradministrators.com

If you submit your claim online at www.hradministrators.com or with the Summit mobile app this form is not needed

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