



HRA CLAIM FORM

Health Reimbursement Arrangement (HRA)

For priority processing, Login to your account and file online!

[Click here to link to the eFile web page!](#)

EMPLOYER NAME:			
PART 1 - COMPLETE FOR ALL CLAIMS			
Social Security Number	Last Name	First Name	Middle Name/Initial
Date of Birth	Date of Hire		
* Street or P. O. Box		* Phone Number	
* City	* State Code	* Zip Code	
* Email Address			

* Complete the address, phone number, and email address sections only if recently changed. Login to your account at www.tri-starsystems.com to verify information on file for you.

PART 2 - HEALTH REIMBURSEMENT ARRANGEMENT (HRA)	See below for explanation of a VALID RECEIPT
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Check the box if this claim is for substantiation of an FSA Debit Card Transaction

Patient Name	Service Dates	Description of Service	Provider Name	Claimed Amount	<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Total HRA Claimed:

PART 3 - Acknowledgement and Signature

I certify that all services and expenses for which reimbursement is claimed by submission of this form were received by me or an eligible dependent. I certify the medical expenses claimed have not been reimbursed and will not be presented for reimbursement through any other health plan. I acknowledge I am responsible for any inappropriate use or disclosure of my information that occurs due to the method I have selected for transmitting this information. I understand that I alone am fully responsible for the accuracy of all information I have provided by submission of this claim form. I understand that by providing incomplete, false, or misleading information on this form that I may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan made in error.

Employee Signature	Date
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VALID RECEIPT: Each claim must be supported by an Explanation of Benefits (E.O.B.) from your insurance company. Please send ANY E.O.B. that you receive that shows a deductible amount, even if you know you are responsible for a portion of the deductible. Claims received that do not include E.O.B.s cannot be processed. If you are missing an E.O.B., please call your insurance company and request that from them. If you have any questions, please call us at the number to the right.

RETURN SIGNED AND DATED FORM WITH SUPPORTING DOCUMENTATION TO:

Tri-Star Systems ATTN: FSA Claim Department 14323 South Outer 40 Road Suite 200 South Chesterfield, MO 63017-5734	PHONE (314) 576-4022 TOLL FREE (800) 727-0182 CLAIMS ONLY FAX (314) 985-0277
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