Please attach documentation to the back of this form

Reset Form

HEARTLAND HEALTHCARE FUND

Health Reimbursement Arrangement (HRA) Claim Form

Name: _____ SS No: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ID No.: _____ Phone No.: (_____) _____

E-mail Address:_____

Please select the type(s) of refund you are utilizing, and then fill in all areas of that section.

❑ 1. Self Payment / Retiree Payment Reimbursements *Please fill month(s) of refund and dollar amount(s).*

1.	$
2.	$
3.	$
Claim Total:	$

❑ 2. Deductible, Coinsurance & other Eligible Reimbursements

(You must seek reimbursement as soon as reasonably possible, but in no event later than two years after the claim was incurred.)
Please attach the Explanation of Benefits (EOB) in the order you have it listed below and fill in with dates of service, description, and claim total, then sign and date below and mail or fax to Wilson-McShane Corporation, Attn: Heartland Healthcare Fund Claims Department

All valid forms of documentation must include the following: Date(s) of Service, Type of Expense, Amount Applied to the Deductible and the Name of the Service Provider. See back of this form for a description of valid forms of documentation.

List each EOB separately

Date(s) of Service	Description	Dollar Amount
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$
	Claim Total:	$

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HRA account to be reduced by the amount requested.

Signature:_____ **Date:**_____

Reminders: Sign and date the Reimbursement Form. Wilson-McShane Corporation cannot process an unsigned form.
Provide an EOB(s) for all expenses submitted. / Keep copies of everything submitted. / Minimum check amount is $25.00.
Cancelled checks or credit card receipts/statements or Provider statements are not valid forms of documentation.
IRS guidelines require that Wilson-McShane Corporation keeps records of all claims and correspondence for three years.
Multiple expenses may be included on one form. If more space is needed, attach additional forms.

Mail completed forms to:

Wilson-McShane Corporation
Attn: Heartland Healthcare Fund Claims Department
3001 Metro Drive - Suite 500, Bloomington, MN 55425
Phone: (952) 854-0795 Fax: (952) 851-3521

HEARTLAND HEALTHCARE FUND

Health Reimbursement Arrangement (HRA)

Valid Form(s) of Documentation for healthcare services:

- Explanation of Benefits (EOB) forms

Valid Forms of Documentation must include all of the following:

- ✓ Date(s) of Service
- ✓ Type of Expense (i.e. eye exam)
- ✓ Amount Applied to the Deductible
- ✓ Name of the Service Provider
- ✓ Participant and/or Patient Name and address

Exceptions

- Itemized list of Prescription purchased or individual itemized receipts from your Pharmacist, whenever an EOB is not processed, will be accepted.

- Itemized statement for glasses and contacts, whenever an EOB is not processed, will be accepted.

Invalid Form(s) of Documentation include:

- Credit card receipts
- Service provider invoices, bills or statements
- Cancelled checks