Frontier Communications- HRA Account

PO Box 26237 - Salt Lake City, Utah 84126
Toll Free 1-877-282-3209

HRA REIMBURSEMENT REQUEST FORM

1. Type or print information (items 1 through 8) on the Employee Section below. Only one patient can be listed on a request form. However, more than one provider/date of service can be listed for that one patient.
2. Enter the total amount for reimbursement for each section(s). (ie, Deductibles, Copay, Coinsurance, Out of Plan, etc)
3. Supporting documentation must accompany this request form. Supporting documentation includes the following:

   Explanation of Benefit (EOB) Statement(s) indicating deductibles, co-insurance, co-payment or amounts in excess of usual and customary charges from any medical/dental/vision plan(s) under which you and/or any of your eligible dependents are covered. If the expense is not covered under your medical/dental/vision plan or is in excess of the plan benefits (ie. Vision yearly benefit has already been utilized), itemized bills from the provider is acceptable. Credit card slips, payment receipts or balance due statements are not considered supporting documentation.
4. Retain copies of supporting documentation for your records.
5. Send completed claim form and supporting documentation, in a personal and confidential envelope, to the Administrative Office at the address above. If you are unsure what is acceptable, please contact the administrative office above.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.

1. Frontier Employee's Name	2. Soc. Sec. No. of Employee	3. Address:
4. Patient's Name	5. Relationship	Phone Number:
7. Email Address		

UNREIMBURSED HEALTH CARE EXPENSES

	Date(s) of Service	Claim Amount to be Reimbursed
Deductible – Medical, dental and vision out of pocket portion	_____	$ _____
Coinsurance / Co-payments – includes prescription and medical copays	_____	$ _____
Not covered by plan (Explanation of Benefits showing reason for denial is required)	_____	$ _____
	Total (Minimum $25.00)	$ _____

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Health Care Reimbursement Account, and I further declare that I have not and will not deduct these expenses on my individual income tax returns. No assignment will be accepted:

_____

Employee Signature Date