



Manual HRA Claim Form - City of Lowell

Use this form to request reimbursement for eligible expenses that have not already been submitted.

- Do not use this form if you already submitted this claim online or on the mobile app.
- Complete all entries on this submission form. Please print legibly or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the claims department. (See submission instructions below.)
- The HRA runs on a plan year 7/1-6/30. All claims must be submitted for reimbursement by 10/31 following the end of the plan year.
- Copayments paid using a Flexible Spending Account (FSA) are not reimbursable through the HRA.

Personal Information	
Employee Name (last name, first name)	Social Security Number

Documentation Required
<p>You must submit documentation with this form. Documentation must include the patient's name, description of service, date of service and amount charged. Examples of acceptable documentation include a copy of the Explanation of Benefits (EOB) from your insurance company, an itemized statement from a provider, or an itemized pharmacy receipt. Cancelled checks, credit card receipts or balance forward statements may supplement the acceptable documentation but will not be accepted alone.</p>

Claim Details					
Date of Service	Patient's Name	Relationship to Employee	Name of Provider	Description of Service	Amount Requested
Total					\$

Authorization and Certification		
<p>Read carefully: This claim will not be processed without your signature.</p> <p><i>I certify that these expenses have been incurred by me, my spouse or my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's income tax return. I further certify that dependent care expenses were incurred for the purpose of allowing me (and my spouse, if applicable) to be gainfully employed.</i></p> <p><i>By signing below, I hereby authorize ConnectYourCare to make covered payments directly to the provider of services listed on the attached bill or to the member. If paid to the member, it is solely their responsibility to make any outstanding payments directly to the provider</i></p>		
<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;"> <div style="border-top: 1px solid black; margin-top: 10px;">Signature</div> </td> <td style="width: 40%; border: none;"> <div style="border-top: 1px solid black; margin-top: 10px; text-align: right;">Date</div> </td> </tr> </table>	<div style="border-top: 1px solid black; margin-top: 10px;">Signature</div>	<div style="border-top: 1px solid black; margin-top: 10px; text-align: right;">Date</div>
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Submission Instructions	
For faster results, fax to: 443-681-4602	Or mail to: Claims Department P.O. Box 622317 Orlando, FL 32862-2317
If you have any questions, please contact Customer Service at 877-292-4040.	