HEALTH REIMBURSEMENT ACCOUNT
REIMBURSEMENT CLAIM FORM

Varipro BENEFIT ADMINISTRATORS

Employee Instructions:

1. Reimbursement form must be complete and clear. **Failure to answer any questions or provide proper documentation may delay payment.**
2. Attached **ALL** pages of your Explanation of Benefits (EOB).
3. Bills from your doctor or other service providers **will not be accepted.**

Participant Information

Employer: _____

Employee Name: _____ **Date of Birth:** ___/___/___

Street Address: _____ ☐ **Check if new address**

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____ ☐ **Check if new email address**

To the best of my knowledge and belief, this Health Reimbursement Claim form is complete and true. I certify that the member has received the services described above on the date of service indicated and that the expenses qualify as a valid medical service under my Employer Benefit Plan. If the expense is for my spouse or dependent, I certify that the person's receipt(s) meets the definition of dependent/spouse in the Plan. I certify that I have not been reimbursed previously for these expenses under any other Flexible Spending Account or Benefit Plan. I understand that these expenses may not be used to claim any federal income tax deduction or credit. ACCEPTANCE OF FACSIMILE OR SCANNED SIGNATURES: Document signatures delivered by facsimile or email/pdf are valid and enforceable. Such facsimile or scanned signatures shall have the same force and effect as an original signature.

_____ _____

Participant Signature *(Required)* **Date:**

Name of Person Receiving Service	Relationship to Employee	Type of Service	Reimbursement Requested
		☐ Medical Deductible ☐ Co-Insurance Reimbursement ☐ Copay	$
		☐ Medical Deductible ☐ Co-Insurance Reimbursement ☐ Copay	$
		☐ Medical Deductible ☐ Co-Insurance Reimbursement ☐ Copay	$
		☐ Medical Deductible ☐ Co-Insurance Reimbursement ☐ Copay	$
		☐ Medical Deductible ☐ Co-Insurance Reimbursement ☐ Copay	$
		Total Reimbursement Requested:	$

Please note this is a generic use form and your Employer Benefit Plan may not reimburse Deductible, Co-Insurance and/or Copays. Please refer to your benefit plan for your specific plan reimbursement schedule.

How to Submit Claims

Electronically:	By FAX:	By Mail:
Email: hra@varipro.com	**FAX Number:** 855-296-1026 **Number of Pages:** _____	Varipro 5300 Patterson Ave SE, Suite 150 Grand Rapids, MI 49512

Customer Service: 800-732-3412