1025 N. Campbell Road, Royal Oak, MI 48067
800.989.8776 • *p:* 248.543.2644 • *f:*248.543.2296 • www.HRPro.com

LEOFF1 Claim/Reimbursement Request

Complete and mail to: HRPro, 1025 N. Campbell Road, Royal Oak, MI 48067

Fax: (248) 543-2296 | Customer Service: (800) 989-8776 | Email: claims@hrpro.com

Claimant's Information:

Employer Full Name:		**Last 4 digits of SSN**					
Street Address:							
City:				**State:**		**Zip:**	
Daytime Phone:		**Email Address** (For claim correspondence only):					

Please check one of the following:

☐ Pay vendors/providers listed directly (*Note MUST include provider/vendor mailing address*)

☐ Reimburse me for claims paid

HRA Claim Information – *Note dependents of active or retired members are not covered*:

Date of Expense/Service	Service Provider Name/Description of Service If paying provider – address required	Covered by any other insurance (including Medicare?)	Amounts of out of pocket expense
	Name: Description: Address:	☐ Yes ☐ No	$
	Name: Description: Address:	☐ Yes ☐ No	$
	Name: Description: Address:	☐ Yes ☐ No	$
	Name: Description: Address:	☐ Yes ☐ No	$
	Name: Description: Address:	☐ Yes ☐ No	$
	Name: Description: Address:	☐ Yes ☐ No	$
		Total Claims:	$

Please Read Carefully

The above is a true and accurate statement of unreimbursed medical care expenses incurred by me on the date(s) indicated. I certify that these expenses were incurred while I was covered under my employer's group medical plan. Copies of the Explanation of Benefits (EOB) form from my health care provider for all expenses are attached to this voucher. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax paid for any expense improperly claimed under the Plan.

Signature:		Date:	

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Instructions:

- Please list eligible medical services and other expenses which are not eligible for payment under any other coverage, including Medicare or other health insurance coverage.
- Only list the amount of the expense you have to pay after insurance pays its share.

Return this form along with:

- A copy of the Explanation of Benefits (EOB) from your health care provider and/or Medicare
- Supplier's bill with itemized list of charges including insurance coverage and dates of service or
- Receipt/Proof of Payment
- Some type of proof is required which includes the date of service, your cost and itemized billing information including billing codes such as CPT and ICD-9 codes.
- **Note if an option of who to pay is NOT selected above, the default will be a check sent directly to you.**

By fax/mail/email to:

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