

## 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](mailto:claims@hrpro.com)

### Claimant's Information:

Employee 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	Name: Description: Address:	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	Name: Description: Address:	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	Name: Description: Address:	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	Name: Description: Address:	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	Name: Description: Address:	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
<b>Total Claims:</b>			\$

### 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:

  
1025 N Campbell Road  
Royal Oak, MI 48067

Tel: (248) 543-2644  
Fax: (248) 543-2296  
Email: [claims@hrpro.com](mailto:claims@hrpro.com)