Southwest Service Administrators, Inc.
Phoenix, AZ Service Center
P.O. Box 43110
Phoenix, AZ 85080-3110

HRA Claim Form

This form must be completed fully, signed and include documentation of expense and proof of payment in order to be considered for reimbursement. Please provide explanation of benefits if applicable.

SECTION A: EMPLOYEE INFORMATION

Last Name	First Name	MI

Email Address	Social Security # or Policy ID	Primary Phone #

Mailing Address	City	State	Zip

SECTION B: MEDICAL CARE Expense Information Provide the following information for each expense item.

Expense incurred by: (Full Name)	Date of Birth	Description of Expense	Date Incurred	Amount requested

FRAUD NOTICE

I certify, these expenses are not covered by insurance or otherwise reimbursable from any other source and is not claimed as a deduction on a federal income tax return. I understand that the Trust Fund is relying on my answers on this form. I represent, under penalty of perjury, that the answers given to all questions on this form are true and accurate. I understand that if I knowingly and with intent to defraud the Trust Fund, provide false information or conceal, for the purpose of misleading, information concerning any fact material thereto, I may be subject to civil and criminal penalties. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this verification form. I will reimburse the Fund for any overpayment made to me or on my behalf due to errors on this form.

Signature _____ **Date** _____