Southwest Service Administrators, Inc.
Phoenix, AZ Service Center
P.O. Box 43110
Phoenix, AZ 85080-3110
Fax (801) 656-6105 / Phone (855) 292-7954

HRA Claim Form

This form must be completed fully, signed, and submitted with the following **required** documents:

- ☐ Itemized statement for each expense listed. Example: dentist statement of work performed, detailed RX receipt from pharmacy. It must provide detail of the services performed or products purchased.
- ☐ A copy of your receipt of payment (credit card receipt, receipt from provider showing payment made)
- ☐ Explanation of Benefits (EOB) for services covered under your Medical/Dental/Vision Carrier, if applicable. **Do not** submit for reimbursements until you have received the EOB that coordinates with your expense.
- ☐ If submitting for multiple family members, complete a separate form for each dependent.

We are unable to process reimbursement if the necessary supporting documentation is not provided. Please submit your claim form along with all supporting documentation to the address above, via fax or via your secure portal login using the secure chat feature. Only goods and services received after your HRA effective date and defined by the IRS as a "medical expense" are eligible for reimbursement. See https://www.irs.gov/publications/p502 for details.

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: Expense Information: Provide the following information for each expense item. Complete a separate form for each dependent.

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** _____