NORTHEAST CARPENTERS FUNDS

HRA Reimbursement Form

Member's Name _____ ID # _____

Address _____

City, State, Zip Code _____ Telephone Number _____

Check type of reimbursement applied for:

_____ Medical Expense _____ Dental Expense _____ Vision/Optical

_____ Post-Tax Medical Insurance Premium (Medical, Dental or Vision)

If you have other insurance, check the type below:

_____ Dental _____ Vision _____Medical (other than NCF)

If you have other insurance, please attach a copy of your ID card for your HRA file.

Reimbursements: Per the IRS, the HRA fund is the payer of last resort. All other insurances must be exhausted first. **You are limited to one form submission/member/month.** Use one form for the entire family and attach unlimited, **original** receipts. You must submit **PAID** detailed bills and corresponding Explanation of Benefits (EOB) if applicable from Insurance showing dates of service, patient name, and diagnosis **along with a receipt showing proof of payment**. **NO PHOTOCOPIES OR FAXES** will be accepted, original bills, Explanation of Benefits and original paid receipts only**. Claims will be paid or denied thru Pro-Flex once a week**. Paper claim submissions must total a minimum of $100.00 (except for January and July when the minimum total can be less than $100.00). You need a minimum HRA balance of $2,000.00 to activate your HRA fund. ***Once activated, HRA money can be used for any Eligible Medical Expense. The Board of Trustees has approved HRA money can be spent down to $ 0.00 effective 7/1/18.*** As a reminder, per IRS guidelines, only Post-Tax insurance premiums are eligible for reimbursement from the HRA. Post-tax means that the insurance premiums are deducted after taxes are taken from your gross wages. Submit pay stubs showing deductions for medical premiums or a letter from the employer verifying the post-tax health insurance premiums including the cost to the employee.

Timely filing is required: You have one year from the date of service (DOS) to submit a bill.

FRAUD WARNING: *Any person who knowingly files a claim containing any false information is subject to criminal and civil penalties. I hereby certify that the paid expenses submitted are for my-self, my legal spouse, or my legal dependent and we are not covered under any other insurance policy that has not been declared.*

Member's Signature _____ **Date:** _____

**Revised 03/01/19* *Download form at* ncf.carpenters.fund