INSURANCE MANAGEMENT SERVICES
P.O. Box 15688 • Amarillo, TX 79105

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) WITHDRAWAL REQUEST

MAIL TO: **Insurance Management Services**
P.O. Box 15688 • Amarillo, TX 79105

Please fax HRA claims to (806) 322-3142

• PART 1. Employee Information

EMPLOYEE NAME (LAST/ FIRST)			*EMPLOYEE DATE OF BIRTH*	*EMPLOYEE SOCIAL SECURITY #*
EMPLOYEE ADDRESS	*City*	*State*	*Zip*	*EMPLOYEE PHONE NUMBER*
EMPLOYER NAME	*EMPLOYER ADDRESS*			*CASE # CERT # DIVISION*

DESCRIPTION OF EXPENSES AND WITHDRAWAL AMOUNT REQUEST

• PART 2. Health Care Expenses (Please place each expense on a separate line)

PATIENT=S FULL NAME	*RELATIONSHIP*	*BIRTHDATE*	*DATES FROM*	*TO*	*TYPES OF SERVICE*	*WITHDRAWAL REQUEST AMOUNT*

TOTAL _____

• PART 3. Submit paid receipt from provider with this claim form.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my HRA were incurred by me (and/or my spouse and/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my HRA. I (or we) will not use the expenses reimbursed through the HRA program as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable by law.

Employee Signature: _____Date: _____