BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

Request For Reimbursement Preferred HRA

Attach a copy of the itemized bill and a Claim Processed Report (if applicable) along with proof of payment. All documentation must include the patient name, description of service provided, date provided, and the charge. Be sure to sign and date this form before sending it with all attachments to the address below.

Blue Cross and Blue Shield of Alabama
Benefits Service Center
P.O. Box 11586
Birmingham, Alabama 35202-1586
FAX 1 877 889-3610

Visit our web site **www.bcbsal.com** for detailed account information

EMPLOYEE INFORMATION

Employee Name *(Please PRINT)* **Last** **First** **MI**	**Preferred Blue Account Number** *(Your Preferred Blue Account Number is your Blue Cross and Blue Shield of Alabama contract number. If you do not have your account number, please contact Customer Service.)*
Home Telephone (Please include your Area Code)	**Work Telephone** (Please include your Area Code)
Company Name	

MEDICAL REIMBURSEMENT INFORMATION

In order to be properly reimbursed, please complete this section for each eligible receipt. (Please attach all necessary receipts.)

Name	Relationship	Date of Birth	Date of Service	Amount
1.	○ Self ○ Spouse ○ Dependent*	MM/DD/YYYY	MM/DD/YYYY	
2.	○ Self ○ Spouse ○ Dependent*			
3.	○ Self ○ Spouse ○ Dependent*			
4.	○ Self ○ Spouse ○ Dependent*			
5.	○ Self ○ Spouse ○ Dependent*			
6.	○ Self ○ Spouse ○ Dependent*			
			TOTAL $	

* Dependent must be considered an eligible dependent under the applicable provisions of the Internal Revenue Code.

I certify that the attached expenses are eligible for reimbursement from my designated Health Reimbursement Arrangement and that they qualify as deductions as outlined by my employer. I request reimbursement up to the limit allowed. I further certify that these expenses have not been reimbursed and are not reimbursable under any other benefit plan.

SIGNATURE OF EMPLOYEE _____ DATE SIGNED _____

Important: This claim form is not used to reimburse you for your Blue Cross and Blue Shield of Alabama health benefits. It may only be used to request a payment from your HRA established by your employer. Payments from such an account may only be made for qualified medical expenses on behalf of qualified dependents where such expenses have not been reimbursed and are not reimbursable by any other benefit plan.