Mission Valley Power Health Reimbursement Account

Administered by CompuSys, Inc.
2156 West 2200 South- Salt Lake City, Utah 84119-1376
Toll Free (800) 926-5581
Fax (801) 401-2716 OR (801) 975-1342
hradept@compusysut.com

HRA REIMBURSMENT REQUEST FORM

1. Type or print information (items 1 through 10) on the Employee Section below. Only one patient can be listed on a request form. However, **all expenses to be reimbursed can be listed for that one patient**.
2. Enter the total amount for which the claim is being made in the appropriate sections. **A minimum of $25 should be accumulated before you submit a claim.**
3. Supporting documentation must accompany this request form. Supporting documentation includes the following:

   Explanation of Benefit Statement(s) indicating deductibles, co-insurance, co-payment or amounts in excess of usual and customary charges from any medical/dental/vision plan(s) under which you and/or any of your eligible dependents are covered. If the expense is not covered under your medical/dental/vision plan an EOB is required showing reason for denial. Itemized bills from doctors, dentists or other suppliers showing insurance payments/adjustments for insured expenses are acceptable.
4. Retain copies of supporting documentation for your records. Your documentation will not be returned to you.
5. Send completed claim form and supporting documentation, in a personal and confidential envelope, to the Administrative Office at the address above.

NOTE: ANY ITEMS FOR WHICH YOU ARE REIMBURSED CANNOT BE CLAIMED AS DEDUCTIONS OR CREDITS ON YOUR FEDERAL INCOME TAX RETURNS.

1. Employee's Name	**2. Social Security Number**		**3. Mailing Address**
4. Patient's Name	**5. Relationship**	**6. Local Union**	
7. Telephone Number	**9. Email Address**		

10. UN-REIMBURSED HEALTH CARE EXPENSES

	Date(s) of Service	Amount to be Reimbursed
Deductible/Coinsurance/Co-Payments for Medical, Dental or Vision	_____	$ _____
Prescriptions (pharmacy ticket is required or the Mail Order packing slip)	_____	$ _____
Expenses Not covered by plan (EOB is required showing reason for denial)	_____	$ _____
	Total	$ _____

I certify that either I and/or my eligible dependents have incurred the expenses for which reimbursement is claimed from the Health Care Reimbursement Account, and I further declare that I have not and will not deduct these expenses on my individual income tax returns. No assignment will be accepted:

_____

Employee Signature Date