Prescription Reimbursement Account Claim Form

The Diocese of El Paso

Employee Information

Employee Name: _____ Social Security Number: _____

Home Address: _____

☐ check here if your address has recently changed

Daytime Email Address: _____ Daytime Phone Number: _____

Medical Expense Claims (for your 105 Account)				
Account Type 105/HRA	Name of Person Incurring Expense	Relationship to Employee	Date of Service	Amount Requested
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				
			Total Amount Requested	

Acceptable Forms of Documentation:
The explanation of benefits from your insurance company or the prescription receipt will be acceptable. All other forms of documentation, including cash register receipts, credit card receipts and cancelled checks are not acceptable.

Employee's Certification for Reimbursement

I certify that the expense for reimbursement requested from my account was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, is eligible for reimbursement under my reimbursement plan. I also agree to notify my Employer if I have reason to believe that any expense(s) for which I have obtained reimbursement is not an eligible medical expense, and also agree on demand to indemnify and reimburse my Employer for any liability it may incur for failure to withhold federal and state income tax or Social Security tax for any reimbursement I receive for an expense which does not qualify as an Eligible Expense pursuant to Section 213d of the Internal Revenue Code.

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

Employee Signature: _____ Date: _____

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