HRA REIMBURSEMENT FORM

Dental & Vision Claims

EMPLOYEE NAME:_____ EMP #_____

EMAIL:_____ PHONE #_____

STREET_____ CITY_____ZIP_____

TO SUBMIT A DENTAL OR VISION CLAIM FOR REIMBURSEMENT:

1. Attach an Explanation of Benefits or an itemized statement showing that the claim has been processed by insurance.
2. Receipts must include the following: name of provider, type of service/purchase, charge for each service. Receipts must be 8.5 x 11 format so photocopies are acceptable.
3. Canceled checks are not acceptable.
4. Expenses must be incurred during the Plan Year. Date of payment to provider is not relevant.
5. All documents must be attached to this reimbursement form. Forms are to be submitted to PHP.
   Mail: PHP TPA Services, 1700 Magnavox Way, Suite 201, Fort Wayne, IN 46804
   Fax: 260-436-7235 or Email: customerservice@phpni.com

CLAIMANT NAME	NAME OF PROVIDER	DATE INCURRED	SERVICES	AMOUNT

I certify that all items required to be reimbursed with the City of Fort Wayne's HRA program will not be covered by any other plan or program of any employer or other person. The City of Fort Wayne does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature_____ Date:_____