



# REQUEST FOR HRA REIMBURSEMENT

Please complete applicable spaces on this form, attach appropriate bills, and forward to EBMS.  
Cancelled checks or balance due statements are not acceptable bills.

Check if address has changed

P.O. Box 21367 · Billings, MT 59104-1367  
Toll Free 1-866-857-8182 · (406)869-6526  
Toll Free Fax 1-877-236-9868 · Email: flex@ebms.com

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

Employee Name \_\_\_\_\_ Member ID # \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Number/Street City State Zip

### UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Incurred	Net Amount
TOTAL MEDICAL CARE EXPENSE CLAIM				

To the best of my knowledge, the statements made within this Request for Reimbursement are complete and true. I am claiming reimbursement for eligible expenses incurred during the applicable plan year by eligible plan participants. **The medical expense requested has not been reimbursed or is not reimbursable by any other health coverage and will not be claimed as an income tax deduction.** I authorize my HRA Account to be reduced by the amount requested.

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_