BPAS

VEBA Health Reimbursement Arrangement (HRA) Request for Reimbursement

Mail, fax or upload completed form and receipts to BPAS at:
820 Gessner Road, Suite 1250, Houston, Texas 77024
Fax: (866) 254-2942 | www.bpas.com
Need help? Call us toll free at 866-401-5272

Did you know you can skip the paperwork and request reimbursement online?
Just login to your account at bpas.com. **It's fast and easy!**

1. PARTICIPANT INFORMATION

LAST NAME | FIRST NAME | MI | Participant Social Security No. (SSN) or Secondary ID # **(REQUIRED)**

MAILING ADDRESS | ☐ Check here if new address | CITY | STATE | ZIP

DATE OF BIRTH | E-MAIL ADDRESS (home or personal recommended) ☐ Check here if new email address | AREA CODE and PHONE #

EMPLOYER NAME

2. PATIENT (COVERED INDIVIDUAL) INFORMATION (REQUIRED)

NOTE: Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires HRA and MERP Plans to report specific information about Medicare beneficiaries covered under these types of plans. Your claim will be automatically denied if you do not fully complete this section.

A. This claim is for:
☐ Myself ☐ Spouse ☐ Qualifying Child
☐ Qualifying Relative ☐ Other:_____

B. Complete this section if claim is for a covered individual other than yourself:
First Name | MI | Last Name
Date of Birth (mm/dd/yyyy) | Gender | SSN

C. Are you separated or retired from the employer that made, or is making contributions to this account?
☐ No
☐ Yes, my date of separation or retirement was:_____

D. Is the covered individual for this claim currently, or have they ever been enrolled in Medicare Part A or Part B? ☐ No ☐ Yes *(complete the following)*
Name *(exactly as it appears on SSN or Medicare Card)* | Medicare Claim No. (HCIN)
Medicare Part A Effective Date *(if applicable)* | Medicare Part B Effective Date *(if applicable)*

3. EXPENSES

The expense(s) listed below are for: ☐ Reimbursement ☐ Debit Card Substantiation Only ☐ Liquidate Account Above HRA Available Balance

Date(s) Service Received	Services Provided By	Description of Service(s) Received *(e.g., deductible, co-pay, out-of-pocket, prescription (RX), dental/ortho, vision, insurance premium, etc.)*	Recurring Expense	Amount
			☐ No ☐ Yes	$
			☐ No ☐ Yes	$
			☐ No ☐ Yes	$
			TOTAL for this covered individual	$

4. PARTICIPANT SIGNATURE

I hereby certify that the information provided in this claim request is true and correct and the submitted claim is not reimbursable from any other source. Spouse/Dependent(s) must be covered under a group health policy in compliance with the ACA Reform in order to be claims eligible.

REMEMBER: You must include an itemized receipt for each expense! If your plan permits for reimbursement of Individual Premium expenses and this claim is for a recurring reimbursement of such expense, you must include a copy of the schedule/declaration page from your insurance company with this form.

X _____
Participant Signature | *Date*