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Health Reimbursement Arrangement Medical Disbursement Form

(Do Not Use for HSA Disbursements)

Employee Information *(please print)*

Name

Address | City | State | Zip

SSN # | Email | Phone | Employer

☐ Please reimburse me ☐ Please pay my provider

MEDICAL EXPENSES *(Attach supporting documentation)*

Your receipts should include all of the following:

☐ Provider's Name ☐ Provider's Address ☐ Amount Billed ☐ Service Provided ☐ Actual Dates of Service (Date of Payment is not Sufficient)

PERSON FOR WHOM EXPENSE WAS INCURRED	DATE(S) OF SERVICE	NAME & ADDRESS OF SERVICE PROVIDER	DESCRIPTION OF SERVICES	AMOUNT
			TOTAL MEDICAL EXPENSES	

Read Carefully

I certify that I am a participant in the Health Reimbursement Arrangement (HRA) Plan and confirm that these expenses, for which reimbursement is requested, have been incurred during the Plan Year while I was covered under the HRA Plan. These expenses have not been reimbursed by any other benefit plan. I understand that I am responsible for the validity of this request and all information pertaining to it. I further understand that I am liable for all related Federal, State or City taxes for any invalid request submitted by me and that I will not claim credit for reimbursed expenses on my individual tax return.

Participant Signature Date

Mail To: Sterling HSA, P.O. Box 71107, Oakland, CA 94612
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