

# Health Reimbursement Arrangement Medical Disbursement Form

**(Do Not Use for HSA Disbursements)**

## Employee Information *(please print clearly)*

Name	SSN #	Email	
Address	City	State	Zip
Phone	Employer	<input type="checkbox"/> Please reimburse me <input type="checkbox"/> Please pay to my provider	

<b>MEDICAL EXPENSES</b>				
<i>(Attach supporting documentation)</i>				
Your receipts should include all of the following:				
<input type="checkbox"/> Provider's Name	<input type="checkbox"/> Provider's Address	<input type="checkbox"/> Amount Billed	<input type="checkbox"/> Service Provided	<input type="checkbox"/> Actual Dates of Service <small>(Date of Payment is not Sufficient)</small>
PERSON FOR WHOM EXPENSE WAS INCURRED	DATE(S) OF SERVICE	NAME & ADDRESS OF SERVICE PROVIDER	DESCRIPTION OF SERVICES	AMOUNT
<b>TOTAL MEDICAL EXPENSES</b>				

### 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
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**Mail To:** Sterling HSA, P.O. Box 71107, Oakland, CA 94612  
**Email To:** customer.service@sterlinghsa.com | **Fax To:** 888-410-7361