Health Reimbursement Account (HRA)
Reimbursement Claim Form

E-MAIL: hra.info@siho.org **FAX**: (800) 391-3539 **PHONE**: (888) 893-7440
MAIL: SIHO Insurance Services, Attn: HRA Department, P.O Box 628, Columbus, IN 47202

Employee/Subscriber Name: _____ SIHO Member ID: _____

The undersigned requests reimbursement for all claimed expenses in the amounts shown below.

Submissions must include a completed claim form, itemized statement (or EOB) with date(s) of service, and a receipt with amount paid.

MEDICAL EXPENSES:

Do you have other medical coverage (other than SIHO if applicable)? ☐ Yes ☐ No
Do you have other dental coverage (other than SIHO if applicable)? ☐ Yes ☐ No
Do you have other vision coverage (other than SIHO if applicable)? ☐ Yes ☐ No

If you answered YES to any of the above questions, you MUST submit your EOB for that expense.

Date Incurred	Provider/Pharmacy	Patient/Member Name	Relationship (EE, SP, Dep)	Amount Requested

TOTAL $ _____

READ CAREFULLY: The undersigned certifies that reimbursement has not previously been requested under this plan, or any other plan, and is not eligible to receive insurance benefits. Expenses reimbursed under this plan cannot be used as a deduction/credit on personal income tax returns.

_____ _____
Employee Signature **Date**