



# HRA Consolidated Claim Form

Return this completed form to:

Mail: MidAmerica Administrative & Retirement Solutions

Attn: HRA, P.O. Box 24927, Lakeland, FL 33802

Email: [claims@MyMidAmerica.com](mailto:claims@MyMidAmerica.com) | Fax: (863) 577.4460 | (855) 329-0095

If additional space is needed for claims, please attach a separate page to include all information requested in the table.

## 1 Your Information

Employer:

Name of Participant:

Current Mailing Address:  Social Security #:

City, State, Zip:  Date of Birth:

Personal Email:  Phone:

Check here if this is a permanent address change. Are you actively employed with this employer?  Yes  No If no, provide separation date: \_\_\_\_\_

## 2 Claim Information

Approved claims are processed within 7-10 business days. Please review the documentation instructions on page 3. Be sure to attach acceptable documentation as outlined in the instructions. Failure to provide the requested information or acceptable documentation may delay your request. Reimbursable expenses must total at least \$100 before being submitted for reimbursement. Applicable distribution fees will be deducted from the total eligible claim amount (per IRS guidelines).

**A. HRA Medical Expenses** – Complete the following table for any HRA medical expenses incurred by the participant, spouse, or eligible dependent.

Date of Expense	Name of Service Provider	Name of Covered Participant, Spouse, or Eligible Dependent	Service Provided	Reimbursement Amount
00/00/00	Sample Provider	Sample Participant	Routine Check-up	\$100.00

I certify that my spouse and/or eligible dependents are enrolled in my employer's group sponsored coverage or another source of group sponsored coverage\* Total HRA Medical Claim: \$

**B. HRA Premium Expenses** - Complete the following table for any HRA premium expenses incurred by the participant, spouse, or eligible dependent. If the expense is recurring and you would like to establish automatic reimbursements, check the box in column R. R stands for Recurring.

Date of Expense	Name of Insurance Provider	Name of Covered Participant, Spouse, or Eligible Dependent	Type of Insurance Premium**	Reimbursement Amount	R	Monthly or Annual
00/00/00	Sample Provider	Sample Participant	Medical	\$100.00	X	Monthly
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

Cancel recurring claim request (select if you wish to stop your current recurring claim) Total HRA Premium Claim: \$

### For Recurring Premium Expense Claims Only

Complete only if you indicated that any of your premium expenses are recurring in the table above.

Please select who should receive the recurring premium reimbursement. If you choose to have the payment made to someone other than yourself, please provide the name and address of where the check should be mailed:

Self  Insurance Provider  My Employer | Name: \_\_\_\_\_ Address: \_\_\_\_\_

### 12 Month Attestation Request

You may submit a 12-month attestation for your recurring premium expense if you are enrolled in your employer's group health insurance or Medicare. If you are enrolled in an individual insurance policy, you are required to provide monthly attestation, per IRS regulations. To download the Monthly Attestation Form, go to [www.MyMidAmerica.com](http://www.MyMidAmerica.com), select Forms, then select Health Reimbursement Arrangement. Please select the type of premium expense for which you are requesting recurring premium reimbursement and check "I certify" box to initiate the 12 month attestation:

Employer Group Health Insurance  Medicare

I certify that my recurring premium expense(s) remains in effect and reimbursable for a 12-month period. I understand after 12 months, I will be required to renew my recurring claim by submitting a new form and providing updated policy documentation for approval. I understand that if at any time during the 12 months my premium amount changes or the policy terminates, I must notify MidAmerica immediately. Failure to alert MidAmerica of a change in policy could result in IRS penalties.

\*Only applies to Integrated HRA Plans. An Integrated HRA is an HRA that you have access to, and your employer contributes to, during active employment. Spouses and/or eligible dependents cannot seek reimbursement from Integrated HRAs if enrolled in individual health insurance coverage.

\*\*Medical, dental, vision, long-term care, Medicare B, C,D, Medicare supplemental plan



# How to File your Claim

## SECTION 1

Complete ALL personal information in this section.

## SECTION 2

### Health Care Expenses

Expenses must be incurred by you, your spouse, or other eligible dependents.

This account reimburses you for services **incurred** for health care purposes only. The type of service rendered determines claim eligibility. Not all health care expenses are reimbursable. (See IRS Section 213(d) for guidelines).

Examples of Common Health Care Expenses:

- Office Visit Co-pays
- Physician Service Co-pays
- Prescription Co-pays
- Insurance Plan Deductibles
- Insurance Plan Coinsurance

For a full listing of eligible medical expenses, please visit <https://www.irs.gov/pub/irs-pdf/p502.pdf>. Please note that not all HRA plan designs allow for full 213(d) reimbursement. To find what your HRA covers, reference your Plan Highlights. This can be found by logging into your account at [www.MyMidAmerica.com](http://www.MyMidAmerica.com), or by contacting our Customer Service team at 855.329.0095.

### Defining Eligibility

You, your spouse, and any qualifying dependents are able to seek reimbursement for eligible medical expenses and premiums from the HRA or FSA. Qualifying dependents include children under the age of 27 at the end of the tax year and any tax dependents.

### HSA / HRA Interaction

If during the HRA plan year, you or your employer, or your spouse or spouse's employer contributed to a Health Savings Account (HSA), your HRA must be restricted for the plan year. While restricted, you can only seek reimbursement for dental, vision, preventative care, and premium expenses from your HRA.

Please review and complete the Account Restriction / Suspension Form if you or your spouse is contributing to an HSA. Notice to restrict is irrevocable during the plan year. A change to remove the restriction must be received prior to the start of the next plan year.

### HRA Premium Expenses

You may only seek reimbursement for premium expenses incurred by you, your spouse, or other eligible dependents once you are no longer actively employed by the plan sponsor. You may request a premium reimbursement for less than the amount owed. For example, if your premium amount is \$1,200 and you only want to be reimbursed for \$800, that is allowed. It is also permissible to be reimbursed for less than 12 months on an annual policy.

### HRA Recurring Premium Expenses

A recurring monthly expense is an expense that you incur monthly in the same amount each month. For example, a monthly health insurance premium may qualify as a recurring monthly expense.

Insurance premiums must also be incurred prior to reimbursement (i.e.; March premium can be reimbursed no earlier than February).

At this time, MidAmerica only establishes recurring claims for monthly premium expenses. If the amount of your recurring expense changes, please notify us immediately by completing an updated claim form.

Please note Long-Term Care Premiums cannot be set up as a recurring claim. A claim form must be submitted each month for Long Term Care premiums.

## SECTION 3

Please select your preferred method of reimbursement. If you are signing up for Direct Deposit for the first time, or if you are changing your bank information, provide your account information.

## SECTION 4

If this distribution is on behalf of a deceased participant, you must provide a copy of the death certificate. Once we have received a copy of the death certificate, MidAmerica will keep it on file for reference for future claims. Therefore, MidAmerica only requires that a copy of the death certificate be sent once.

## SECTION 5

**SIGN the claim form.** This is required on all submissions; otherwise the claim will not be processed.

## POSSIBLE HRA FEES

HRA distributions may be subject to a \$5.00 distribution fee per paper claim (up to an annual maximum of six distribution fees per calendar year).

If your claim is being made payable to a third party (Insurance Provider or Employer) your claim will not be subject to a distribution fee. However, if the claim is being paid to you, your claim may be subject to a distribution fee. For more information specific to your Employer's HRA plan, please refer to your Plan Highlights.

## ONLINE CLAIMS SUBMISSION

You are able to submit your claims online at any time. Claims submitted online have a quicker turnaround time and reduced distribution fee of \$2.50 per claim (up to an annual maximum of six distribution fees per calendar year.)

- Go to [www.MyMidAmerica.com](http://www.MyMidAmerica.com)
- Select "Submit Claims" from the blue header at the top of the page.
- Simply follow the prompts on the screen until you receive a confirmation of successful submittal.

## DOCUMENTATION REQUIREMENTS

**Documentation must include the following:**

- Date of service
- Description of service
- Cost of service
- Individual receiving the service
- Provider of the service

**Notes on documentation:**

**Explanation of Benefits (EOB)**

- Your plan may require an EOB for claim approval. Please refer to your Plan Highlights for details on the documentation required by your plan for reimbursement.
- An EOB is a statement returned to you from the insurance carrier indicating the amount for which you are responsible. Remember any medical, dental, or vision expense covered by insurance in part or in full must first be submitted to your insurance carrier.

**Long-Term Care Premium Policies**

- Payments made for long-term care premiums are subject to annual maximums for the year in which payment is made. Therefore, proof of payment is required for all claim requests.
- Long-Term Care Premiums cannot be set up as a recurring claim. A claim form must be submitted each month for Long Term Care Premiums.

**Recurring Premium Reimbursements**

- The first initial setup for reimbursement requires detailed documentation.
- The documentation must show:
  - Name/type of recurring claim to be reimbursed
  - Amount of claim
  - Frequency of claim
  - For instance, a copy of the premium notice from your insurance carrier would be acceptable

**Attesting to your Recurring Claim**

You may submit a 12-month attestation for your recurring premium expense in Section 2 of the claim form, if you are enrolled in your employer's group health insurance or Medicare.

**If you are enrolled in an individual insurance policy,** you are required to provide monthly attestation, per IRS regulations.

To download the Monthly Attestation Form:

- Go to [www.MyMidAmerica.com](http://www.MyMidAmerica.com)
- Select Forms
- Then select Health Reimbursement Arrangement

**Failure to submit a monthly attestation if you are enrolled in an individual policy will prevent reimbursement approval.**

**When a Medical Necessity Form is Needed**

You may need to complete and have your doctor sign a Medical Necessity Form showing that the service is medically necessary. Common services that require this form include:

- Counseling
- Physical / Occupation / Massage Therapy
- Acne Treatment