rha
innovative insurance solutions

Mail or Fax claim forms to:
rha
5502 58th Street, Suite 700
Lubbock, TX 79414
Voice: 800-680-0892
Fax: 806-784-3555

Dental/Vision Reimbursement Claim Form

INSTRUCTIONS

1. Please complete all sections below.
2. If expense is covered by insurance, submit to appropriate carrier.

EMPLOYEE INFORMATION

Employee Social Security #	Company Name	New Address (**circle one**) Yes No
Last Name	First Name	
Address	City / State / Zip Code	
Daytime Phone	Email	

EXPENSES

Patient Name	Description of Eligibility Expense	Incurring Dates	Total Amt of Bill	Amt to be Reimbursed

Provider Signature: **Date:**

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or my eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Dental/Vision Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. I understand reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

Employee Signature *(Required)*	Date