

Reimbursement request form with Individual Coverage HRA (ICHRA)



Employer name: _____

Participant name (First, MI, Last): _____

Social security number: _____

Address: _____

City, ST, Zip: _____

Date of birth: _____ Phone number: _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claimant Name	Date of Service	Amount	Code*	Type of Services/Item Purchased	Claim Reference Number
John Sample	10/1/2022	\$150.00	IC	Insurance Premium	Example
			IC		01
			IC		02
			IC		03
			IC		04
			IC		05
			IC		06

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I understand that the individual coverage HRA will reimburse me for a medical care expense incurred during a month only if I have (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during that month. Similarly, I understand that the individual coverage HRA will reimburse me for a medical care expense my family member incurred during a month only if my family member has (or had) individual health insurance coverage, Medicare Part A and B, or Medicare Part C during that month. By signing below, I am attesting that I (or my family member) meet this requirement.

Please note that you must complete both pages 1 and 2 of the claim form if you are requesting reimbursement from an Individual Coverage Health Reimbursement Account (ICHRA).

For reimbursement from an Individual Coverage Health Reimbursement Account you must sign and date this form below. Your family member does not need to sign or date the form. Please mail OR fax the completed form (but not both) with any required documentation within the claim timeline defined in your Summary Plan Description (SPD) to:

Lifetime Benefit Solutions Claims Dept.
PO Box 211126
Eagan, MN 55121
Fax # (877) 256-7228

A. I, _____, am requesting reimbursement for a medical care expense incurred during the month of _____, and for that month I am (or was) covered under the following health coverage: _____.

Instructions: Complete the following if you're requesting reimbursement of a family member's medical care expense from the individual coverage HRA.

B. I, _____, am requesting reimbursement for a medical care expense incurred by, during the month of _____, and for that month this family member is (or was) covered under the following health coverage: _____. I hereby affirm that the above information is true and accurate.

Instructions: If you are requesting reimbursement for a medical care expense incurred by you and a family member, you must complete both A and B above.

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

Reimbursement request instructions

- For faster reimbursement processing you may be able to submit your claims online at lifetimebenefitsolutions.com.
- Complete the top section, including Social Security Number or Employee ID.
- Submit one expense (either a product or service) per row, even if items are contained on the same receipt.
- Label the receipts to correspond to the Claim Ref #.
- If you have more items than the form can accept, use additional forms.
- Do not "lump" or group items together.
- The expenses you submit must qualify as valid expenses under the terms of the Plan, and the claimant receiving the services must be a qualifying individual as defined in the Plan.
- Retain a copy of the Reimbursement Request Form and receipts for your own personal records
- Do not send credit card receipts, original receipts or cancelled checks.
- **If you are submitting a request for reimbursement for insurance policy premiums, the bill from the insurance carrier must identify the participant, premium amount, coverage period and policy number.**
- Call Lifetime Benefit Solutions Customer Service with questions at (800) 327-7130 during standard week-day business hours.
- Mail OR fax (but not both!) completed form with required documentation to:

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Eagan, MN 55121
Fax # (877) 256-7228

