GBS HRA REIMBURSEMENT FORM

Section 1: Employee Information	
Employee Name:	Social Security #:
Home Address:	
Employer Name:	Phone #:

PLEASE READ CAREFULLY:

Please attach a copy of your Explanation of Benefits (EOB) from the insurance carrier or paid receipt* from the pharmacy showing your out of pocket expenses (such as copayment, coinsurance or deductible) to this GBS HRA Medical Reimbursement Form and submit to Group Benefit Services by using the mailing address, fax number or e-mail address below:

Group Benefit Services, Inc.
PO Box 4368
Lutherville, MD 21094
Toll Free: 800.337.4973
Fax Number: 410.321.8053
HRAClaims@gbsio.net

Upon receipt, Group Benefit Services will determine your eligible reimbursement benefit and return an Explanation of Benefit and reimbursement check to you.

If you have any questions, please feel free to contact our Customer Service Representative at the phone number listed above.

Employee Signature: _____ Date: _____

*Note: In order for a paid receipt from the pharmacy to be acceptable for claim substantiation it MUST contain the following information: Member's name, Provider's name, itemized service detail, date of service and paid amount.