HRA REIMBURSEMENT REQUEST

Allegiance℠ by Cigna Healthcare

To send scanned claims, or for additional forms, go to: *www.askallegiance.com*
Please print legibly in black or blue ink.

Employer Name:	Total Number of Pages Submitted:
Employee Name:	Attention:
Participant ID: *(Social Security Number or, if assigned, Allegiance ID)*	Comments:

Faxed and mailed claims may take longer to process than electronic claims and will not appear in your account until reimbursement occurs. For quick and easy processing, please login online to submit your claim.

To receive reimbursement faster sign up for direct deposit online.

Service	Service Date	Deductible Amount
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____

The expense will be considered for HRA reimbursement if you attach a copy of the Explanation of Benefits (EOB) from your insurance companies documentation.

Documentation other than an insurance EOB will be considered for flex reimbursement only, if applicable. If the required documentation is not attached, your reimbursement will be delayed.

I certify that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my qualified dependents, and/or spouse. These expenses have not previously been reimbursed under any plan and I will not seek reimbursement under any other health plan. I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed may not be claimed on my individual tax return at the end of the year.

Signature (required): _____Date: _____

☐ Check here if your address has changed.

New address: _____

***Please inform your employer if your address has changed.*

2024