P. O. Box 4346
Missoula, MT 59806

HRA REIMBURSEMENT REQUEST

To send scanned claims, or for additional forms, go to:
www.allegianceflexadvantage.com

FAX: 406-523-3149 or toll-free 877-424-3539 PHONE: toll-free 877-424-3570

Please print legibly in black or blue ink.

Employer Name: _____ Total # of Pages Submitted: _____

Employee Name: _____ Attention: _____

Participant ID: _____ Comments: _____
(Social Security Number or, if assigned, Allegiance ID)

You may check the status of your claim, within 48 hours, by logging in to your account at www.allegianceflexadvantage.com.

Service	Service Date	Expense Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

YOUR CLAIM WILL BE REVIEWED FOR HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ELIGIBILITY FIRST, THEN CONSIDERED FOR FLEX ELIGIBILITY.

☐ Do not forward this claim to my flexible benefits account after HRA processing.

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. 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.
_____