HRA REIMBURSEMENT REQUEST

Allegiance® a Cigna Company

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. If you have not received reimbursement within two weeks, please contact an Allegiance representative at 877-424-3570.	
If you would like future payments directly deposited into your bank account, include a voided check with this form or sign up on the Allegiance website.	

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, third-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.*

2014

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