# HRA Claim Form Instructions

**What is the recommended method to submit my claims?**

- **Submit Claims Online:** To submit claims online, visit **mynbsbenefits.com**. Select **Claims** tab, choose **Claim Request**, fill out required fields, attach receipts, mark certification box, and click **Submit**.
- **Submit Claims using Mobile App:** Sign in, choose submit claim from main menu, enter requested info, and add a receipt by using the camera on your mobile device.
- Additional methods to submit claims manually are noted at the bottom of your claim form.

**How do I avoid delays processing my claim?**

- Submit receipts either online or using the NBS mobile app for quicker reimbursement:
    - **Register to use our online website**: Manage all aspects of your account easily online. For instructions to register online, email our service center at **service@nbsbenefits.com** for assistance.
    - **Download the free NBS mobile app on your Android or IOS device:** Manage your account and upload receipts using the camera feature.
- **Direct Deposit:** Sign up for direct deposit and receive money directly to your banking account the next business day following processing completion. Visit **mynbsbenefits.com**, click user name in the top right corner, choose edit link directly above **reimbursement method**, select **direct deposit**, and fill out necessary banking information.
- **Complete a continual reimbursement form**. Avoid the hassle of submitting claims and receipts each month by submitting a continual reimbursement form for your orthodontia claims. Receive your money automatically as funds are received from your employer. Remember to save your receipts to submit at the end of the plan year. Visit **mynbsbenefits.com** and print out a form using the resource tab.
- When submitting a paper claim:
    - Complete section 1 and 2 of claim form and indicate if there is an address change.
    - Enclose receipts in same order as services listed on claim form.
    - **Sign and date claim form**. NBS is unable to complete processing without a signature.

****Please note, due to the customizable nature of HRA plans, not all items/services suggested on this instruction page may be eligible. To avoid denial of your claim(s), please review what items/services are eligible under your plan before submitting claims for reimbursement.**

**What information is required on all receipts by the IRS?**

- HRA claims require an Explanation of Benefits (EOB) to complete processing
- Name of service provider or merchant name
- Date service was performed or items purchased (*Billing/statement dates and services for future dates are not eligible)*
- Description of service *(Credit card receipts are insufficient unless "co-pay," "office visit," or "InstaCare," is indicated on the receipt.)*
- Amount of service/item
- Drug name and/or prescription number *(if applicable)*
- Orthodontic services will require an orthodontic contract or financial agreement from the provider

***Insufficient information on receipts provided may delay the processing of your claim(s). Please allow 24-48 hours for claims in good order to be processed.**

**Customer Service Center –** Do you have additional questions? Please contact our customer service center by emailing service@nbsbenefits.com or call (855) 399-3035, and we would be happy to assist you.

# HRA Claim Form

nbs national benefit services

## Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print in blue or black ink when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

## 1 Personal Information

Employee Name (First Name, Last Name) _____ Company Name _____

Street Address _____ City _____ State _____ Zip Code _____ ☐No ☐Yes Address Change?

Phone Number _____ Social Security Number _____

## 2 HRA Claims

| | Date of Service MM | DD | YY | Provider | Service Rendered | Person Receiving Service | Amount |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |

**Total Health Care Expense** _____

## 3 Eligible Expenses

Please see your current SPD for a summary of your benefit

## 4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____



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