# HRA Claim Reimbursement Form

## How to Submit Your Claim

**By Fax** (415) 454-2928
**Online** marinbenefits.com
**By Mail** 700 Larkspur Landing Circle, Suite 199
Larkspur, CA 94939

## Questions?

**Customer Service** (415) 526-1401
**Email** helpdesk@marinbenefits.com

## Member Information

**Name (Last, First, Middle Initial)**

**Employer Name**

**Address (Street)**

**Email Address**

**Address (City, State, Zip)**

**Phone Number**

❑ **Check Here If New Address**
Address changes will be verified with HR

## Healthcare Expense Claims

| Date | Patient Name | Provider Name | Description | Amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | **Total Healthcare Expense Claims** | **$** |

**Attach copies of appropriate receipt(s) and submit with this claim form. Documentation should include your Explanation of Benefits (EOB) from your provider.**

## Signature of Member

*By signing below, I certify that my statements on this form are true and accurate. I certify that all expenses for which reimbursement is claimed were incurred either by me or by my eligible dependent(s). I certify that the medical expenses claimed are not covered by insurance and cannot be reimbursed under any other health plan coverage. I further understand that reimbursed expenses cannot be claimed as a credit on my personal income tax return.*

**Signature**

**Date**

Reimbursements are made by check unless you are set-up with Direct Deposit through the Marin Benefits Web Portal. Please allow 2-3 weeks for processing and payment of your reimbursement. Failure to provide appropriate documentation will result in delays in the processing of your claim.