MARIN BENEFITS & INSURANCE SERVICES

HRA Claim Reimbursement Form

How to Submit Your Claim Securely

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

**Submitting claims via email may risk exposing your healthcare information*

Questions Regarding Your Claim?

Customer Service (415) 526-1401 ext. 1
Help Desk Email helpdesk@marinbenefits.com

Claimant Information

Name (Last, First)	Employer Name
Home Address (Street)	**Email Address**
Home Address (City, State, Zip)	**Phone Number**

Healthcare Expense Claims

Service Date	Patient Name	Provider Name	Expense Description	Amount
			Total Reimbursement Request	**$**

Please attach a copy of your receipt/statement detailing the services provided, date of service, and the total out-of-pocket expense. **For expenses that apply to your deductible or co-insurance please submit a copy of the Explanation of Benefits (EOB) from your insurance carrier.**

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** _____

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.

Direct Deposit Authorization Form

To enroll in Direct Deposit Reimbursement from your Health Reimbursement Account, please complete the form below and return to Marin Benefits. All information must be supplied in order for Direct Deposit to be established.

Participant Information

Employer Name _____

Your Name _____ **Last four SSN** _____

E-mail Address _____ **Phone Number** _____

Bank Account Information

Bank Name _____

Account Number _____ **Routing Number** _____

Account Type ☐ **Checking** ☐ **Savings**

Please attach VOIDED check here

I hereby authorize Marin Benefits and the bank listed above to deposit reimbursements from my Health Reimbursement Account (HRA) directly into my bank account designated on this form.

If funds to which I am not entitled are deposited to my account due to error or any other reason, I authorize Marin Benefits to direct the bank to return said funds to Marin Benefits.

I understand that my deposit may not be credited to my account for up to 3 business days after the transaction has been sent to the bank for processing.

I understand that this authorization will remain in effect unless I advise Marin Benefits that I have revoked it. Furthermore, I understand that it is my responsibility to notify Marin Benefits of all future changes to my bank account number and routing number. If I fail to notify Marin Benefits of changes of this nature, I will be responsible for reimbursing Marin Benefits for all applicable bank charges.

_____ _____

Signature **Date**

Fax or Mail completed form to:

Marin Benefits and Insurance Services
700 Larkspur Landing Circle, Suite 199
Larkspur, CA 94939
Fax: 415-454-2928