Health Reimbursement Arrangement (HRA) Claim Reimbursement Form

How to Submit Your Claim

Online www.marinbenefits.com
By Fax 415-454-2928
By Mail 6366 Commerce Blvd. Suite 293
Rohnert Park, CA 94928
By Email* helpdesk@marinbenefits.com

Questions Regarding Your Claim?

Customer Service 844-947-3845
Help Desk Email* helpdesk@marinbenefits.com

**If you chose to submit your claims via email you understand you may risk exposing your protected healthcare information.*

Claimant Information

Name	Employer Name
Email	**Phone**

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 plans linked to a group health plan you must submit a copy of the Explanation of Benefits (EOB) from your health 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(s).