Please attach documentation to this form

Minneapolis Retail Meat Cutters and Food Handlers Health & Welfare Fund

Health Reimbursement Account (HRA) Claim Form

Participant Name: _____ Social Security No: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ID No.: _____ Phone No.: (_____) _____

Please select the type(s) of refund you are requesting, and then fill in all areas of that selection.

❑ 1. Self Payment Reimbursements *Please fill in week(s)/month(s) of refund and dollar amount(s).*

1.	$
2.	$
3.	$
4.	$
5.	$
Claim Total:	$

❑ 2. Deductible, Coinsurance & other Eligible Reimbursements

(Must be submitted within twelve months of the date on which the expense was incurred in order to be eligible for reimbursement)
Please attach the Explanations of Benefits (EOB) in the order you have listed them below and fill in with dates of service, description, and claim total, then sign and date below and mail or fax to Wilson-McShane Corporation at the address listed below.

All valid forms of documentation must include the following: Date(s) of Service, Type of Expense, Amount Applied to the Deductible and the Name of the Service Provider. See back of this form for a description of valid forms of documentation.

List each EOB separately

Date(s) of Service	Description	Dollar Amount
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$
	Claim Total:	$

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or for my elgibile dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HRA account to be reduced by the amount requested.

Signature:_____ **Date:**_____

Reminders: Sign and date the Reimbursement Form. Wilson-McShane Corporation cannot process an unsigned form. Provide an EOB(s) for all expenses submitted. / Keep copies of everything submitted. / Minimum check amount is $25.00. Cancelled checks or credit card receipts/ statements or Provider statements are not valid forms of documentation. Multiple expenses may be included on one form. If more space is needed, attach additional forms.

Submit completed forms and documentation to:

Wilson-McShane Corporation
Attn: MRMC Claims Department
3001 Metro Drive - Suite 500 • Bloomington, MN 55425
Phone: (952) 851-5797 Fax: (952) 851-3521

Minneapolis Retail Meat Cutters and Food Handlers Health & Welfare Fund

Health Reimbursement Account (HRA)

Valid Forms of Documentation

Valid Form(s) of Documentation for healthcare services:

- Explanation of Benefits (EOB) forms

Valid Forms of Documentation must include all of the following:

- ✓ Date(s) of Service
- ✓ Type of Expense (i.e. eye exam)
- ✓ Amount Applied to the Deductible
- ✓ Name of the Service Provider
- ✓ Participant and/or Patient Name and address

Exceptions

- Itemized list of Prescriptions purchased or individual itemized receipts from your Pharmacist, whenever an EOB is not provided to you, will be accepted.

- Itemized statement for glasses and contacts, whenever an EOB is not provided to you, will be accepted.

Invalid Form(s) of Documentation include:

- Credit card receipts
- Service provider invoices, bills or statements
- Canceled checks