Contact Information & Claims Submission:
888-599-1515 ~ 856-470-1200
800-238-0876 (Fax)
flexclaims@iaatpa.com
IAA - PO Box 5082
Mt. Laurel, NJ 08054
www.iaatpa.com

Hamilton Township School District
Copayment Reimbursement Claim Form

Please indicate the appropriate Account:
☒ Health Reimbursement Account (HRA)

Employer Name		
Last name	**First name**	**Social #**
Address	☐Check box if this is a new address	
City	**State**	**Zip**
Email		Phone

Please fill in all requested information and attach a copy of your Explanations of Benefits and Pharmacy Information Sheet for the services listed below. If this form is incomplete, it will be returned to you.

	Expense # 1	Expense # 2	Expense # 3	Expense # 4
Date Medical Service or Item Actually Provided				
Name of Person Receiving Medical Service and His/Her Relationship	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**
Type of Service Provided (Medical or RX)				
Reimbursement Amount Requested				

	Expense # 5	Expense # 6	Expense # 7	Expense # 8
Date Medical Service or Item Actually Provided				
Name of Person Receiving Medical Service and His/Her Relationship	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**	Name: ☐ **Self** ☐ **Spouse** ☐ **Dependent**
Type of Service Provided (Medical or RX)				
Reimbursement Amount Requested				
			Total Reimbursement Requested	

I authorize that to the best of my knowledge, my statements on this Form are true and complete. I certify all of the following: Either I, my Spouse or my Dependent has received the services described above on the dates indicated, or the expenses qualify as valid Medical Care Expenses under Code Section 213(d), as further defined in the Plan document (the "Plan"). I certify that all drugs were obtained legally in the United States. These expenses have not previously been submitted for reimbursement under the Plan. They have not been reimbursed under this Plan or any other plan, and I will not seek reimbursement for them under the major medical plan or any other health plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (*e.g. a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me*).

Employee Signature: _____ **Date:** _____
*(Employee Signature **must** be provided in order to process this form)*

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Copayment Reimbursement Claim Form Documentation

Medical Reimbursements

1. Complete the Claim Form
2. Attached a copy of your Health Care Carrier **"Explanation of Benefits"** (EOB)
3. Submit your completed Claim Form and EOB to IAA for processing
4. Claims can be submitted via Mail, Email, or Fax

All documentation should clearly show date of service, procedure performed and should prove the claim was initially processed by your health care carrier.

Acceptable Documentation

1. A copy of the Explanation of Benefits (EOB) you receive from your health care carrier
2. You can also login to your health care carriers web site and print a statement

(*Receipts, canceled checks, credit card receipts and proof of payment or notice of payment due **will not** be accepted.*)

Prescription Reimbursements

1. Complete the Claim Form
2. Attached a copy of your **"Pharmacy Prescription Sheet" or Pharmacy Print out**
3. Submit your completed Claim Form and Pharmacy Prescription Sheet to IAA for processing
4. Claims can be submitted via Mail, Email, or Fax

All documentation should clearly show date of service, procedure performed and should prove the claim was initially processed by your health care carrier.

Acceptable Documentation

1. The Pharmacy Prescription Sheet
2. A print-out from your pharmacy

(*Receipts, canceled checks, credit card receipts and proof of payment or notice of payment due **will not** be accepted.*)

This plan is governed by IRS guidelines. In order to satisfy IRS requirements documentation is needed to process your claim(s). When submitting for reimbursement, please complete and provide necessary documentation. This will quicken the processing time of your claim(s). Please visit our website www.iaatpa.com for additional forms.