HRA REIMBURSEMENT FORM

Dental & Vision Claims

EMPLOYEE NAME:____ EMP #_________________

EMAIL:____ PHONE #_________________________

STREET______________________________________ CITY________________________ZIP________

TO SUBMIT A DENTAL OR VISION CLAIM FOR REIMBURSEMENT:

1. Attach an Explanation of Benefits or an itemized statement showing that the claim has been processed by insurance.
2. Receipts must include the following: name of provider, type of service/purchase, charge for each service. Receipts must be 8.5 x 11 format so photocopies are acceptable.
3. Canceled checks are not acceptable.
4. Expenses mut be incurred during the Plan Year. Date of payment to provider is not relevant.
5. All documents must be attached to this reimbursement form. Forms can be sent to AGA at 7605 Westfield Dr, Fort Wayne IN 46825, Fax to: 489-0365 or emailed to: HRA@aga-tpa.com

CLAIMANT NAME	NAME OF PROVIDER	DATE INCURRED	SERVICES	AMOUNT

I certify that all items required to be reimbursed with the City of Fort Wayne's HRA program will not be covered by any other plan or program of any employer or other person. The City of Fort Wayne does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature____ Date:_____________