Retiree Healthcare Reimbursement Account(RHRA) Reimbursement Claim Form

SEARV RHRA

Name (Last, First, Middle Initial)

Address (Street)

E-Mail Address

Address (City, State, Zip) ☐ Check Here if New Address

Phone Number (Including Area Code)

Reimbursement requests must be submitted by MARCH 31st for prior year expenses
Monthly Self-Pay Contributions ARE NOT Eligible Expenses

Date Expense Incurred (mm/dd/yyyy)	Name of Service Provider (If Applicable)	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate EOB(s), bill(s), or receipt(s) and submit with this claim form.		**Total Healthcare Expense Claim**		**$**

***Return Form along with EOB(s), bill(s), or receipt(s) to:**

SEARV RHRA
Three Gateway Center, Ste. 1625, 401 Liberty Ave.
Pittsburgh, PA 15222
Phone – (412) 325-2805
Toll Free – 1 (866) 520-9174
Fax – (412) 325-2801

Michele Gentile: michele@cwb-a.com

Read Carefully: The undersigned SEARV Participant certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the RHRA Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. RHRA may require reimbursement of claims subsequently determined to be in-eligible. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim that is provided by the undersigned. The undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan if the payment has been reimbursed by another plan.

SEARV Participant's Signature **Date**