Custom Design Benefits

HRA Claim Form

Health Reimbursement Account

Submit Claims To:
Custom Design Benefits, Inc.
5589 Cheviot Road
Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-2901
CustomFlex@CustomDesignBenefits.com

Employer: _____

Employee: _____ Employee or SSN #: _____

☐ Check if new address Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

E-mail: _____ Phone: _____

TO ENSURE WE CAN PROCESS YOUR CLAIM:

ATTACH A COPY OF THE EXPLANATION OF BENEFITS (EOB) -- This must be provided for each patient. The EOB should also show your year to date totals that have applied toward your deductible and out of pocket expenses.

Please note that cash register receipts, balance due bills and credit card statements do NOT have enough information for submitting claims.

CLAIMS RECEIVED LESS THAN 24 HOURS PRIOR TO THE PLAN'S SCHEDULED CHECK ISSUING DATE WILL BE PROCESSED ON THE NEXT SCHEDULED DATE.

Get your money faster...Sign Up for Direct Deposit! Simply visit our Custom Flex web portal to sign up, or complete and return a direct deposit form. The form is located on www.CustomDesignBenefits.com, click 'Members", and see the Forms section.
*Not all Health Reimbursement Accounts utilize direct deposit, so check with your employer to see if this option is available.

HRA REIMBURSEMENTS REQUESTED

Date of Service	Name of Service Provider	Service Description	Patient Name	Claim Amount
			Total Amount of HRA Claim	$

Read Carefully: The undersigned participant in the Plans 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 Company's Plans with respect to such expenses and that the health expenses have not been reimbursed or are not reimbursable under any other health plan coverage. 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 which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plans which relate to such expense.

_____ _____

Employee's Signature Date

To view claims and other account information visit www.CustomDesignBenefits.com, click Member Portal, then click Custom Flex: FSA/HRA/HSA.