



Please type or print all information.

COMPANY NAME:

Alpena Montmorency Alcona Educational Services District

Social Security Number: (for security purposes please provide at least the last 4 digits of you ss#)

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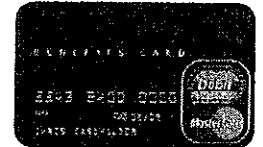
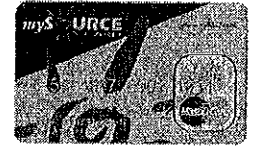
Employee Last Name:

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Employee First Name:

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ONLY USE THIS FORM IF YOU HAVE ONE OF THESE CARDS



MEDICAL EXPENSES

- Documentation for each request will need to show date of service, description of service provided and charge for service as well as the providers name and address.
- For expenses that apply to your deductible or co insurance please submit a copy of the Explanation of Benefits (EOB) from your insurance company
- For prescriptions that apply to your deductible please submit the cash register receipt or RX tag along with the claim form.
- Please itemize your expenses to help assure proper processing. If you have more expenses than this form allows please attach a separate form. If you do not itemize your expenses we will process your claim based on the documentation received
- Mail claims to: 9246 Portage Industrial Dr, Portage MI 49024; Fax: 800-731-1922 or 269-488-6255 or email to hra@basiconline.com
- For questions please call 888-472-0777 or 269-488-6785

HRA debit card used for this expense	Date of service	Provider name or name of store	Amount
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> YES <input type="checkbox"/> NO			