Kereon HSA
"Guiding You To Better Health"

HRA Claim Form

Account Holder Information

Account Holder Name:		Account Number or Social Security Number:	
Address:		Daytime Phone Number:	
City:	State: Zip:	☐ New Address ☐ New Phone Number	☐ New Email
Employer:		E-mail (Opt.):	

Distribution Instructions

Total Reimbursement to Employee: $ _____

Total Reimbursement to Provider: $ _____

☐ Deposit into my personal bank account on file. ☐ Mail a check to me

☐ **New** Bank Account or **Change** Bank Account: Bank Account Type: ☐ Checking ☐ Savings

Routing #: _____

Bank Name: _____ Account #: _____

Expense Detail

Send Payment	Date of Service	Patient Name	Relationship	Provider Name & Address (If payment is to the Provider)	Provider Account #	Amount
☐ Me ☐ Provider						
☐ Me ☐ Provider						
☐ Me ☐ Provider						
☐ Me ☐ Provider						
☐ Me ☐ Provider						
☐ Me ☐ Provider						
☐ Me ☐ Provider						

☐ **Continued on the Next Page**

Account Holder's Certification For Distribution

I certify that this distribution requested from my HRA plan was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

Account Holder's Signature: _____ **Date**: _____/_____/_____

Submit to: **FAX:** 952-449-3619 **Mail to**: KereonHSA, 1161 Wayzata Blvd E., #184, Wayzata, MN 55391 6.15

Email: Claims.kereon@KereonHSA.com