MARIN BENEFITS & INSURANCE SERVICES

HRA Claim Reimbursement Form

How to Submit Your Claim

By Fax (415) 454-2928
Online marinbenefits.com
By Mail 700 Larkspur Landing Circle, Suite 199
Larkspur, CA 94939

Questions?

Customer Service (415) 526-1401
Email helpdesk@marinbenefits.com

Member Information

Name (Last, First, Middle Initial)

Employer Name

Address (Street)

Email Address

Address (City, State, Zip)

Phone Number

❑ **Check Here If New Address**
Address changes will be verified with HR

Healthcare Expense Claims

Date	Patient Name	Provider Name	Description	Amount
			Total Healthcare Expense Claims	**$**

Attach copies of appropriate receipt(s) and submit with this claim form. Documentation should include your Explanation of Benefits (EOB) from your provider.

Signature of Member

By signing below, I certify that my statements on this form are true and accurate. I certify that all expenses for which reimbursement is claimed were incurred either by me or by my eligible dependent(s). I certify that the medical expenses claimed are not covered by insurance and cannot be reimbursed under any other health plan coverage. I further understand that reimbursed expenses cannot be claimed as a credit on my personal income tax return.

Signature

Date

Reimbursements are made by check unless you are set-up with Direct Deposit through the Marin Benefits Web Portal. Please allow 2-3 weeks for processing and payment of your reimbursement. Failure to provide appropriate documentation will result in delays in the processing of your claim.