



IMAGINE 360
12770 Merit Dr., Suite 200
Dallas, TX 75251

HRA PLAN
STATEMENT OF CLAIM
FAX # 972-238-7853

GENERAL INSTRUCTIONS

1. Complete ALL questions in parts A, B, C and/or D and E.
2. Attach itemized bills and/or receipts to this statement. All bills must contain: (a) the identification of the service provider; (b) name of person services was provided for; (c) dates of service; and (d) itemized services rendered and amount charged for each.
3. Make sure the claim does not include items for more than one plan year. Use a separate claim form for each plan year.
4. If Group & Pension Administrators, Inc. also administers your other medical benefits, you may include a claim form for that as well.
5. If Group & Pension Administrators, Inc. does not administer your medical benefits and this is a claim for medical reimbursement, then also include a copy of your explanation of benefits from your medical plan showing the medical expenses not reimbursed.
6. After receiving a claim, the Claims Administrator will send the Employee an itemized statement explaining covered and non-covered expenses.

PART A – Employer Information

1. Employer Name Allied Digital Services, LLC	2. Plan # H880321	3. Group # H880321
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PART B – Employee Information

1. Employee Name (first, middle, last)	2. Birthdate	3. Certificate #
4. Mailing Address (street, city, state, zip)	5. Social Security #	

PART C – Unreimbursed Medical Expense Claims

1. Claim is for: ☐ Self ☐ Spouse ☐ Other Dependent Relationship: _____	2. Patient's Name	3. Sex ☐ Male ☐ Female	4. Birthdate
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PART D – Claims Reimbursement Detail

1. Claimant Name (Patient)	2. Dates of Service From To	3. Provider Name	5. Amount
a.			
b.			
c.			
d.			
e.			
f.			
g.			

PART E – Employee Certification

READ CAREFULLY. The undersigned Participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under their Employer's HRA 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. The undersigned fully understands that he/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 Plan which relate to such expense.

1. Date	2. Employee's Signature
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