HRA Reimbursement Request Form

Peralta CCD	Retiree Name:	Employer code: YGT

Claimant Information ☐ Check here if mailing address is new

Last Name, First Name Middle Initial		
Home Address City / State Zip Code		
Phone No. & EMAIL / Date of Birth		
SSN / Relationship to Retiree		

*Please note this form is NOT for Medicare premium A, B & D Reimbursements, only HRA.

Items required in submitting this form:

(1) Complete all pertinent information in the spaces provided, sign, date & return to Navia Benefit Solutions, Inc.

(2) Attach an itemized Explanation of Benefits (EOB) or receipt from Insurance Carrier/Provider to support requested reimbursements.

(3) EOB/RECEIPT MUST INCLUDE: Date of service, description of expense, cost of expense, amount patient responsible for clearly listed for approval.

Date of Expense	Type of Expense	Expense Incurred By	Requested Amount
Total Medical Requested			

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 the plan with respect to such expenses, and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is 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 the payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense. The participant also acknowledges that the participant alone is responsible for direct payment to the service provider of the expense being requested for reimbursement and that the employer, the plan, or the plan administrator will not be liable for any lack of payment to the service provider should the participant fail to submit payment for the expense to the service provider after receiving reimbursement from the Plan.

Signature _____ Date _____

P.O. Box 5809 Fresno, CA 93755-5809
Phone No. 559-256-1320 Toll Free 866-777-1320
Fax No. 559-475-5780 Email: spsclaims@naviabenefits.com

You may upload your claim via the online portal or use the submit your claim through mail, email or fax