Request for HRA Reimbursement
CLAIM FORM

Lucent Health - Wisconsin
PO Box 7020
Appleton, WI 54912-7020

Phone: 920-968-4613
Toll Free: 877-236-0844
Fax: 920-968-4616
Website:lucent.wealthcareportal.com

Employer Name – Woodmen - Select HRA

Employer Group #P61

	Last:	First:	MI	SS#:	
☐ Please check if this is a new address					
	Street:	City:	State	Phone:	

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim. All information below must be completed.

For all reimbursable expenses, please attach copies of your Medical Explanation of Benefits (EOB). All bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Canceled checks are not acceptable receipts.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), will not be reimbursed by any other plan and, to the best of my knowledge and belief, are eligible for reimbursement under my employer's Health Reimbursement Account. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ *Date:* _____ / _____ / _____

Once complete, please mail to Lucent Health - Wisconsin at PO Box 7020, Appleton, WI 54912-7020 OR Fax to: 920-968-4616
(Retain a copy for your records.)