Sentinel Benefits
& FINANCIAL GROUP
Custom Solutions for Life and Wealth

Town of Arlington HRA
Claim Form

Instructions

1. Complete the information below. Please print.
2. Attach the documentation in the order in which you have the expenses listed.
3. The documentation must contain the date(s) of service, expense incurred and the name of the service provider.
4. Cancelled checks and credit card receipts are not a valid form of documentation.
5. This form must be signed and dated in order to be processed and approved.
6. Please submit the form with your supporting documentation using one of the following methods:

Fax: **(781) 213-7304**
Email: **claims@sentinelgroup.com**
Mail: **100 Quannapowitt Parkway, Suite 300 Wakefield, MA 01880**

Employee Information

Social Security Number _____

Last Name _____ **First Name** _____

Street Address _____

City _____ **State** _____ **Zip** _____

Email Address **Phone Number**

Claim Information

Date of Service	Provider of Service	Outpatient Surgery	Emergency Room	High Tech Imaging	Inpatient/ Outpatient	Amount Requested
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	

Total Amount:

Claim Information - Out of Pocket Maximum Met*

*In the event that any one member or family has out of pocket costs for covered services from in-network providers, that are not already reimbursed by the HRA (including prescription drug copayments, deductibles and office visit copaments) and that exceed $1,250 per member/$2,500 per family in total per year, the HRA will provide reimbursement of 100% of the cost for covered services from in-network providers over $1,250 per member/$2,500 per family in total per year.

Date of Service	Provider of Service	Type of Service/Expense	Amount Requested

Total Amount:

Certification

I request payment from my health reimbursement account (HRA) for the expenses itemized above. I certify that I have not previously requested reimbursement under this plan or from any other source for these expenses. I further certify that I have met all of the requirements for eligible healthcare expenses. I understand that reimbursement expenses cannot be claimed on my personal income tax return or my flexible spending account (FSA).

_____ _____

Employee's Signature Date