AMWINS CONNECT ADMINISTRATORS
PO Box 4368
Lutherville, MD 21094
Toll Free: 800.337.4973
Fax Number: 410.321.8053
gbs.hraclaims@amwins.com

AMWINS CONNECT ADMINISTRATORS
HRA REIMBURSEMENT FORM

Employee Name: _____ Social Security # _____

Home Address: _____

Employer Name:_____ Phone #_____

PLEASE READ CAREFULLY:

Please attach a copy of your Explanation of Benefits (EOB) from the insurance carrier or paid receipt* from the pharmacy showing your out of pocket expenses (such as copayment, coinsurance or deductible) to this HRA Medical Reimbursement Form and submit to Amwins Connect Administrators by using the mailing address, fax number or e-mail address shown above.

Upon receipt, Amwins Connect Administrators will determine your eligible reimbursement benefit and return an Explanation of Benefit and reimbursement check to you.

If you have any questions, please feel free to contact our Customer Service Representative at the phone number listed above.

_____ _____

Employee Signature **Date**

***Note: In order for a paid receipt from the pharmacy to be acceptable for claim substantiation it MUST contain the following information: Member's name, provider's name, itemized service detail, date of service and paid amount.**