

**HRA CLAIM
FORM
City of Lowell**

Administered By:
UltraBenefits, Inc.
100 North Parkway, Suite 302
Worcester, MA 01606

Website: www.ultrabenefits.com
Phone: (508) 438-0007
(866) UltraBenefits
Fax: (508) 438-2519

EMPLOYEE NAME	Plan # J15
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EMPLOYEE ADDRESS (STREET, CITY, STATE, ZIP)

IMPORTANT NOTICE 	TO AVOID DELAYS IN PROCESSING THE ATTACHED MEDICAL CLAIMS, PLEASE ENCLOSE ITEMIZED STATEMENTS WHICH INCLUDE DATE OF SERVICE, TYPE OF SERVICE, AMOUNT CHARGED, DIAGNOSIS AND PATIENT'S NAME ALONG WITH COPY OF EXPLANATION OF BENEFITS FROM YOUR HEALTH PLAN.
<p>Any person who knowingly and with intent to defraud any benefit plan or insurance company, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.</p> <p align="center">***Please note that this HRA runs on a plan year 7/1-6/30. All claims must be submitted for reimbursement by October 31st following the end of the plan year***</p>	

By signing this form, I hereby authorize UltraBenefits, Inc. to make covered payments directly to the provider of services listed on the attached bill or to the member. If paid to the member, it is solely their responsibility to make any outstanding payments directly to the provider.

SIGNATURE OF EMPLOYEE	SIGNATURE OF PATIENT (if not Employee) or Parent, if minor	DATE
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PROVIDER/SUPPLIER NAME	AMOUNT	PATIENT NAME	SERVICE DATE	PAY PROVIDER?
	\$			Y / N
	\$			Y / N
	\$			Y / N
	\$			Y / N
	\$			Y / N
	\$			Y / N
	\$			Y / N
TOTAL	\$			