ICHRA Claim for Reimbursement

Use this form to submit claims for reimbursement for individual coverage health reimbursement arrangements (ICHRA). If you have any questions while completing this form, please call us at (701) 258-9848.

1. Participant Information

First Name, Last Name:	Last 4 of SSN:	Employer Name:
Participant Address:	City, State, Zip:	

2. About Your Expenses

Use one line in this section for each eligible expense type. If you have multiple expenses of the same type, you may request payment on one line for the entire date range.

Name of Insurance Carrier	Dates of Coverage	Name of Insured	Expense Amount Claimed	General Description (Premium)
1				
2				
3				
4				

3. Required Premium Expense Documentation

Please provide copies of documentation for the premiums that are eligible for reimbursement. If we are unable to read the documents due tot the quality of the copy, we may need to request additional information. Here are some examples off acceptable documentation for plan premiums:

- Insurance premium confirmation letter
- Monthly or quarterly billing statement
- Insurance premium payment coupon
- Bank statement showing electronic premium withdrawal

4. Attestation of Coverage and Participant Signature

By submitting this form, I certify that: I, as the individual or on whose behalf the reimbursement is (or was) enrolled in individual health insurance coverage or Medicare Part A and B or Medicare Part C for the month during which the medical care expense was incurred. Furthermore, all expenses I am submitting for reimbursement were incurred by me or another individual eligible under my company's applicable benefit plan(s). All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's applicable benefit plan(s). None of the expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. I am fully responsible for the sufficiency and accuracy of information relating to this reimbursement submission.

I attest to the following:

I, ______________________________, am requesting reimbursement for a medical expense incurred during the period of ______________________________, and for that period I am (or was) covered under the following health coverage provided by the following carrier: ________________________________.

I hereby affirm that the above information is true and accurate.

Signed: ____________________________________

Date: __________________________

You must sign and date this form. Please return the completed form to Fronteer Professional Services, Inc., 1838 E Interstate Ave Ste B, PO Box 1315, Bismarck, ND 58502. Fax: (701) 258-1011. Email: customerservice@fpspayroll.com.