HRA Payment Request
(Health Reimbursement Arrangement)

PAY TO: _____

_____

_____

_____

Policy Period: ☐ **July 1 2025 thru June 30, 2026**

Type of Coverage: ☐ **Indvidual** ☐ **Family**

Amount Requested: **$** _____

NOTE: All Requests must be accompanied by a copy of a member's BCBS Summary of Health Plan Payment(s) which will be received either by mail at the end of each month or by establishing a Member Login at BCBSMA.com to download an "Activity Summary"

Employee Signature: _____ _____
DATE

To be completed by Benefits Manager

Exp Acct

Health Insurance - HLTH DEDUCT REIMB 0001-0914.519001-0000 $ _____

Received: _____
DATE

Approved by: _____