Claim Form

(Instructions on next page)

Employee Information

Last Name, First Name	SSN / Employee ID #
Home Address (Street, City, State, Zip Code) ☐ Please update my address on file	**Phone Number**
Employer Name	**Email Address**

Did you know you can submit paperless claims online or via the MyNavia mobile app? Just take a picture and submit!

HRA

Service Date(s)	Type of Service	Provider's Name	Services For Whom	Net Cost
			Total Reimbursement Request $ _____	

Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my HRA, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HRA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HRA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse and/or dependents. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information, please contact your employer. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. By providing an email address, I consent to receive all possible communications from Navia Benefit Solutions, agents, and subcontractors regarding the Plan via email. I may withdraw consent at any time without charge by contacting Navia by phone, email, or mail. To update your email address contact Navia Benefit Solutions by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HRA to be reduced by the amount(s) shown above.

Participant's Signature	
X_____	Date_____

Claim Form Instructions

1. Complete employee information section. Be sure to write legibly to ensure proper processing.
2. Itemize your expenses in the table provided and attach copies of your documentation.

   Documentation must clearly show the date of service, type of service, and final cost of service. Examples of acceptable documentation include itemized bills/invoices, or the Explanation of Benefits (EOB) from your insurance carrier.

   - ❖ If your employer offers an HRA and you are enrolled in a plan that only offers reimbursement for deductible, coinsurance, and/or copays an EOB is required for claim submission.

   Proof of payment is not required in order to reimburse medical/dental/vision services.
3. Be sure to sign the claim form and submit! Please fax, email or mail a signed claim form, but choose one method only.

Submit to:

Email: 105@naviabenefits.com
Fax: Local (425) 709-7125 or Toll-free (866) 831-6222
Mail: Navia Benefit Solutions
PO Box 53250 Bellevue, WA 98015
Phone: Local (425) 452-3421 or Toll-free (866) 897-1996

Claims status is available online. Please allow at least two (2) full business days for Navia to process your claim.