Request for Reimbursement
Alpha Industries
HRA Claim Form

Submit claims via email to:
gente Employee Benefits
Attn: Alpha HRA Claims
122 Parish Drive
Wayne, NJ 07470
Fax: 973-694-2913
E-mail: alphaclaims@gente.solutions
Phone: 866-693-7254 (Helpdesk)

1. Personal Information

SSN: XXX-XX __ __ __ __ DOB _____/_____/_____

Employee Name:_____

Home Mailing Address:_____ E-mail Address:_____

City:_____ State: _____ Zip: _____Daytime Phone # _____

☐ **Check if this is a new address**

2. Payment Instructions (Check One)

☐ Please Pay Employee (Proof of payment must be included)

☐ Please Pay Provider (Provider Invoice must be included)

3. Claim Filing Instructions

- Submit a completed and signed claim form. Incomplete or unsigned claim filings will be returned, PLUS
- Attach the Explanation of Benefits (EOB) from your primary health insurer credit, PLUS
- IF YOU REQUEST PAYMENT TO YOUR PROVIDER, attach the invoice from your provider. Please verify that your providers invoice requests payment that is equal to what the insurers EOB states you owe. If the invoice and EOB conflict, the claim will be paid based on the EOB and payment will be made to the employee.

4. Expense Reimbursements Requested (Limit of 4 requests per claim form)

	Expense #1	Expense #2	Expense #3	Expense #4
Date of Service				
Patient Name				
Patient Relationship	☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child
Reimbursement Requested	$	$	$	$
Pay To	☐ Provider ☐ Employee ☐ Split	☐ Provider ☐ Employee ☐ Split	☐ Provider ☐ Employee ☐ Split	☐ Provider ☐ Employee ☐ Split

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred by my legal dependents and/or myself incurred during a period while the undersigned was covered under The Alpha Industries HRA plan. I certify that these expenses have not been and will not be reimbursed from any other health plan coverage.

Employee Signature_____ Date_____