90 DEGREE BENEFITS
A Turn For The Better

HRA (SECTION 105)
REIMBURSEMENT FORM

Employee Name:			
Employee's Address: Street	City:	State:	Zip:
Patient Name:	Patient DOB: d/m/y		
Employer*:____			

***required**

COMPLETE THE TABLE BELOW AND ATTACH A COPY OF THE APPLICABLE EXPLANATION OF BENEFITS			
Date of Service	Patient Name	Provider/Facility Name	Expense Submitted
*Total Expense Submitted $*___________________________________			

I certify that to the best of my knowledge that the above listed expenses are not being reimbursed by any other medical plan and are eligible under the Section 105 Plan sponsored by the Employer.

Signature　　　　　　　　　　　　　　　　　　　　　　Date

Send this form and required documentation to the address listed below or you can fax to 203-877-9558 or email to CDHPClaims@90DegreeBenefits.com

90 Degree Benefits | 291 S. Lambert Road, Suite 4 | Orange, CT 06477

203.876.1660 | 90degreesbp.lh1ondemand.com