CINCINNATI city of

Catilize Health Third Party Administrator

Integrated HRA Claim Form – City of Cincinnati Employees

EMPLOYER INFORMATION

Employer Name: **City of Cincinnati**

SEND THIS FORM, COPIES OF RECEIPTS, EXPLANATION OF BENEFITS & ANY OTHER CLAIM DOCUMENTATION TO:

Catilize Health
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143

Email: CinciHRA@catilizehealth.com
(Phone): 877-872-4232
(Fax): 877-599-3724

PARTICIPANT INFORMATION

Employee Name:	Employee ID #:	Date of Birth:

PRESCRIPTION REIMBURSEMENT INFORMATION:

Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:
Date:	Name of Drug:	Co-Pay Amount:

PHYSICIAN OFFICE VISITS:

Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:
Date of Visit:	Co-Pay Amount:

EXPLANATION OF BENEFITS: EOBs

Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:
Date of Service:	Amount Owed:

Documentation submitted must include: Patient name, date of service, type of service or service code, drug name or Rx number if prescription.

Please Note: *All medical claims must be submitted first through your Non-City sponsored group health plan. An explanation of benefits (EOB) will be provided to you. Only medical and/or prescription expenses approved by your Non-City sponsored group health plan will be reimbursed. You must submit (1) Explanation of Benefits, (2) Receipt of paid service if paid at time of service and (3) Rx receipt. Cancelled checks and/or credit card statements are NOT sufficient proof of your claim. Failure to provide all information will cause a delay in reimbursement.*

EMPLOYEE STATEMENT:

I hereby certify that the information contained on this Reimbursement Claim Form is to the best of my knowledge and belief true and correct and each item is eligible for reimbursement. I understand that any expenses reimbursed are NOT tax deductible on my individual or joint federal tax return. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for the Integrated HRA benefits.

I certify that the amounts above have not been reimbursed under any other health care plan or program, federal, state, or government program, worker's compensation, or any other policy of health insurance, and that I will not seek reimbursement under any of the aforementioned plans, including an HSA, HRA or FSA account.

Employee Signature: ______________________________ **Date:** ________________

All 2021 claims must be received no later than 90 days after plan year ends or 90 days after termination

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