Municipality of Anchorage

RETIREE MEDICAL FUNDING PROGRAM TRUST FOR POLICE OFFICERS AND FIREFIGHTERS

Health Reimbursement Request Form

Check if new Address ☐

Name: _____ Retiree ID: _____

Address: _____ Phone: _____

_____ Email: _____

	Expense #1	Expense #2	Expense #3	Expense #4	Expense #5	Expense #6
Date medical service provided						
Patient						
His/her relationship to you	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Spouse ☐ Dependent
Proof of expense attached	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Total Expense						
Amount reimbursed previously or paid/ payable under another plan						
Reimbursement Requested						

I certify that the expenses for which I am seeking reimbursement from the Health Reimbursement Arrangement (HRA) have been incurred by me, or by an individual who qualifies as my spouse or my dependent for federal income tax purposes. I further certify that these expenses have not been reimbursed, nor shall be reimbursement be sought, from any other health plan coverage, including a Health Savings Account (HSA) I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.

I authorize a deduction from my HRA Account for the expenses listed above.

_____ _____

Retiree Signature Date

For Office use only	Amount Approved	Date Approved	Approved by:

Reason Expense Denied:

- ☐ Please sign
- ☐ Provide substantiation indicating what service or product was purchased.
- ☐ Ineligible Expense
- ☐ Previously reimbursed on:
- ☐ Other: _____

PO Box 196650 Anchorage, AK 99519-9980 Fax: (907) 249-7622 Email: BretzLD@muni.org

Reimbursement Request Process

Important Dates: Reimbursement claim forms received by the plan administrator on or before the 25th day of each month will be processed beginning the first business day of the following month. Reimbursement checks are mailed within ten days thereafter.

Health Reimbursement Request forms submitted after the 25th of the month will be held and processed during the next claim cycle.

Only expenses submitted on the approved RMFPT Health Reimbursement Request Form will be considered.

You may submit reimbursement claims **NO LATER THEN 365 DAYS** after the end of the calendar year in which the expense is incurred.

Retiree ID numbers are located on the members' quarterly financial statements.

Each expense must be listed separately. For each expense include the date of service, name of person receiving the service and his/her relationship to you.

Copies of supporting documentation that indicates what product or service was rendered are required for each expense listed on the form to satisfy substantiation requirements for medical reimbursement. Originals should not be provided unless requested by the plan administrator. Please keep a copy of all forms and receipts for your records.

Incomplete or ineligible reimbursement claims will be responded to in writing.

Eligible medical expenses not covered by insurance or other means can be considered for reimbursement by the MOA Retiree Medical Funding Progam Trust for Police Officers and Firefighters (RMFPT).

Health Reimbursement Request Forms are available on the MOA Retiree Medical Funding Progam Trust website at www.muni.org/medical. For those retirees without internet, a form can be mailed upon request.

Submit forms: MOA Retiree Medical Funding Progam Trust
Mail: For Police Officers And Firefighters
PO Box 196650
Anchorage, AK 99519-9980

Fax: 907-249-7622

Email: BretzLD@muni.org

If you have any questions regarding this form or your benefits, please, contact the Plan Administrator at (907) 267-5094 or (877) 343-8203.

HRRF 02/2019