HSA Claim Form

Please Print

Mail or fax to:

American Health Resources
11 North 2nd Avenue
St. Charles, IL 60174

Phone: 800-570-3757
Fax: 888-815-3921

Please submit the following:

*Provide bill or:
*Explanation of Benefits (EOB)

Requested amount: $_____

☐ Reimburse me
☐ Pay provider
☐ Do not negotiate a better price for me

Insured Name: _____

Address _____

City _____

State _____ Zip _____

Last 4 digits of SS# _____

Employers Name _____

Patient Name _____

Provider Name _____

Address _____

City _____

State _____ Zip _____

Provider Phone Number _____

Employee Signature _____

Provider Acct Number _____

Reimbursement Guidelines:

1 The reimbursement request is for an eligible expense
2 Reimbursement has not been received from insurance
3 Please attach a copy of the insurance explanation of benefits (EOB) or bills to document each reimbursement request.
4 Please do not submit originals of bills or insurance statements. Keep originals for your records.

PLEASE NOTE: If you incur a large claim ($250 or more) and you do not have enough in your account to cover it, we can set up a payment plan to pay your doctor or hospital out of your account for you. Please call us at 800-570-3757 if you want us to make these arrangements for you.

I hereby authorize AHR, its representatives and agents to utilize and release personal health care information, including this authorization, as I have provided to them for the purpose of paying medical claims and/or obtaining a reduction in medical claim liability on behalf of me or one of my family members. I also authorize them to act as my/the patient's authorized representative for those purposes and authorize my health care provider to disclose or utilize such information in discussions with them for such purpose. I authorize the transmission of this information via email or facsimile, and hold AHR, its representatives and agents and my health care providers harmless from any and all claims that might arise from the risks associated with accidental disclosure of medical information, which is inherent in an email, or facsimile transmission. This authorization, in its entirety, may be revoked in writing at any time by me except to the extent that any actions have been taken in reliance thereon. This authorization is valid for the period of time necessary to pay the claims contained herein and shall expire when these financial transactions have been concluded.