



STERLING HSA®

475 14th Street,
Suite 650
Oakland, CA 94612

P.O. Box
71107
Oakland, CA 94612

T: 1.800.617.4729
F: 1.877.517.4729
www.sterlinghsa.com

Health Reimbursement Arrangement (HRA) Medical Claim Form

Employer Information *(please print)*

Name

Address

City

State

Zip

SSN #

Email

Phone

Employer

Please reimburse me Please pay my provider

MEDICAL EXPENSES

(Attach supporting documentation)

Your receipts should include all of the following:

Provider's Name Provider's Address Amount Billed Service Provided Actual Dates of Service
(Date of Payment is not Sufficient)

PERSON FOR WHOM EXPENSE WAS INCURRED	DATE(S) OF SERVICE	NAME & ADDRESS OF SERVICE PROVIDER	DESCRIPTION OF SERVICES	AMOUNT
TOTAL MEDICAL EXPENSES				

Read Carefully

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and were incurred while I was covered under my Health Reimbursement Arrangement. Supporting documentation from my service provider(s) for all expenses are attached to this voucher.

Participant Signature

Date

Mail To: Sterling HSA, P.O. Box 71107, Oakland, CA 94612
Email To: customer.service@sterlinghsa.com | **Fax To:** 877-617-4729