Version 2023.1

ICHRA Claim Form

Complete and return this form to EMPOWER. Please be sure to include the required documentation with this claim form. Please consult your ICHRA notice for eligible expenses.

Mail To:
EMPOWER
7309 E 21st St N Suite 110
Wichita, KS 67206

Fax To:
(316) 687-2113

Email To:
customerservice@empowerflex.com

Employer _____ Last 4 of SSN _____

Employee Name_____ Phone (_____) _____-_____

Email _____

Premium Reimbursement Expense Claims		
Dates of Coverage	Insurer/Coverage Name	Net Amount
Attach appropriate receipt(s) and submit with this claim form	**Total ICHRA Expense Claim**	**$**

Health Care Expense Claims			
Date Expense Incurred	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form		**Total ICHRA Expense Claim**	**$**

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For Premium Reimbursement claims, attach a receipt showing the following:

- The name of the item or service
- The cost
- Vendor name
- Date of purchase (and service dates for premiums)

For Health Care Expense claims, attach an Explanation of Benefits (EOB) from your insurer for the purchase

Complete the following for any expenses being reimbursed from the ICHRA.

I, _____, am covered under the following individual coverage health insurance (name of insurer coverage): _____.

The submitted medical expense has not been previously reimbursed and reimbursement will not be sought for the expense from any other arrangement or health plan.

Also complete the following if a family member's expenses can be reimbursed from the ICHRA.

The following family member(s) _____ is/are covered under the following individual coverage health insurance (name of insurer coverage): _____.

The submitted medical expense has not been previously reimbursed and reimbursement will not be sought for the expense from any other arrangement or health plan.

I hereby affirm that the above information is true and accurate.

Employee Signature_____ Date _____/_____/_____