Allegiance℠ by Cigna Healthcare

HRA Reimbursement Request

To send scanned claims, or for additional forms, go to: *www.askallegiance.com*

Please print legibly in black or blue ink.

Employer Name:	Total Number of Pages Submitted:
Employee Name:	Attention:
Participant ID: *(Social Security Number or, if assigned, Allegiance ID)*	Comments:

Faxed and mailed claims may take longer to process than electronic claims and will not appear in your account until reimbursement occurs. For quick and easy processing, please login online to submit your claim. If you have not received reimbursement within two weeks, please contact an Allegiance representative at 877-424-3570.

To receive reimbursement faster sign up for direct deposit online.

Service	Service Date	Expense Amount
		$
		$
		$

You must submit independent, third-party documentation of your expenses with this claim form. If the required documentation is not attached, your reimbursement will be delayed.

I certify that the claimed expenses were incurred to diagnose, cure, treat, mitigate, and/or prevent a disease and cover only myself, my qualified dependents, and/or spouse. These expenses have not previously been reimbursed under any plan and I will not seek reimbursement under any other health plan. I understand that items purchased merely to promote general health are not reimbursable. I further understand that expenses reimbursed may not be claimed on my individual tax return at the end of the year.

Signature (required): _____ Date: _____

☐ Check here if your address has changed.

New address: _____

***Please inform your employer if your address has changed.*

2024