



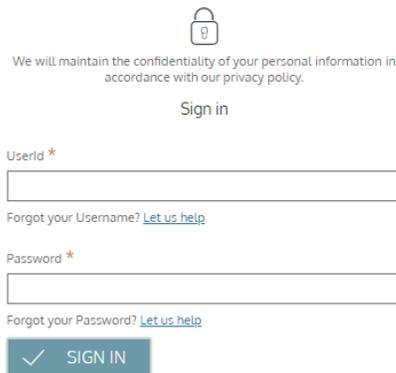
## Health Reimbursement Account Claim Process

Navigate to [www.ffga.com](http://www.ffga.com)

Under **Login**, select **Individuals**, choose **HSA/FSA/HRA Login**

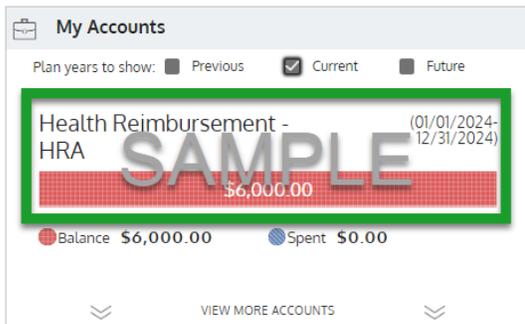
Click on the **Sign In** button  (if you have not registered for online account access, select **Register** to complete the registration process)

Enter your **User ID** and your **Password**, click **Sign In**



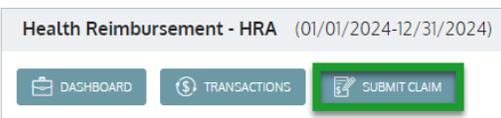
The screenshot shows a login form with a lock icon and a privacy policy statement: "We will maintain the confidentiality of your personal information in accordance with our privacy policy." Below this is a "Sign in" label. The form contains two input fields: "Userid\*" and "Password\*", each with a "Forgot your [Userid/Password]? [Let us help](#)" link. At the bottom is a "SIGN IN" button with a checkmark icon.

Click on **Health Reimbursement -HRA** from the dashboard



The screenshot shows the "My Accounts" section of the dashboard. It includes a filter for "Plan years to show:" with options for "Previous", "Current" (selected), and "Future". A card for "Health Reimbursement - HRA" is highlighted with a green border, showing a balance of \$6,000.00 and a period of (01/01/2024-12/31/2024). Below the card, it displays "Balance \$6,000.00" and "Spent \$0.00". A "VIEW MORE ACCOUNTS" link is visible at the bottom.

Click on **Submit Claim**



The screenshot shows a navigation menu for the "Health Reimbursement - HRA" account. It includes three buttons: "DASHBOARD", "TRANSACTIONS", and "SUBMIT CLAIM", which is highlighted with a green border.

## Select the **Service Type: Co-insurance, Copay or Deductible** for HRA Claims

Submit Claim ✕

CLAIM DETAILS > DOCUMENTATION > CONFIRM SUBMISSION

**Claim Form Instructions**

Please identify the Service Date(s), Claim Amount, Claimant, Provider and Account Type, then attach your additional claim documentation.  
Click "OK" when finished.

\* - Required Field

Service Type \*

Service Start Date \*

Service End Date

Claimant

Claim Amount \*

Provider Name

Account Number

Comments

Enter the following information related to the claim: Service Start Date, Service End Date, Claimant Name, Claim Amount, Provider Name, Account Number (if applicable) and Comments

Service Start Date \*

Service End Date

Claimant

Claim Amount \*

Provider Name

Account Number

Comments

Select an option: **Attach Claim Receipt** or **Validate Later**

Submit Claim ×

CLAIM DETAILS DOCUMENTATION CONFIRM SUBMISSION

*i* Please Choose a Validation Method to Continue

 **Attach Claim Receipt**  
Take a photo of your receipt or attach an existing document now.

 **Validate Later**  
Submit the claim without a receipt now, knowing a receipt may be required for claim approval.

× CANCEL

- **Attach Claim Receipt** – allows you to take a photo or attach a saved document using the **Browse or Drag & Drop** feature to the claim (HRA claims MUST be accompanied by an Explanation of Benefits (EOB) provided by the major medical insurance company) – Click **Next**

Submit Claim - Add Receipt ×

 Upload Receipt

 **DRAG & DROP**  
your receipts here

× CANCEL

- **Validate Later** – choosing validate later will save your claim to the portal, however it will not be processed for reimbursement payment until proper documentation is uploaded to the expense

Confirm Submission – Read and Authorize the submission by clicking the box and choosing **Submit**

Submit Claim ×

CLAIM DETAILS DOCUMENTATION CONFIRM SUBMISSION

Claim Details

Amount:	\$3,500.00
Claimant:	██████████
Service Type:	CO-INSURANCE
Service Start Date:	Jan 1, 2024
Service End Date:	Jan 1, 2024
Comments:	Surgery copay
Provider:	Dr. Sample

 ██████████.FFA.docx

I authorize my account(s) to be reduced by the amount requested. To the best of my knowledge and belief, the statements within this claim are complete and true. I am claiming reimbursement only for eligible expenses incurred by eligible plan participants during the applicable plan year.

I certify that these expenses have not previously been reimbursed by this or any other benefits plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction. I also understand that I may be asked to provide further details (i.e. a letter of medical necessity from a medical practitioner certifying that the expense is to treat or cure a medical condition or a more detailed certification from me).

× CANCEL

Normal claim processing time is 1-3 business days. Once a claim is processed and approved, the payment should be reimbursed within 2 business days if Direct Deposit has been established.

If any assistance is needed with your HRA Claim; please contact us at:

866-853-3539, option 2