Reimbursement Claim Form

Please complete this form to request reimbursement of expenses incurred by you and/or eligible dependents. Itemized documentation of each expense must be provided. For questions, contact Customer Service at (888) 345-7990.

Employee Name:	**Employer Name:**
Employee ID: **First Initial, Last Name & Last 4 digits of SS# (no spaces)**	
E-mail Address:	**Phone #:**
Home Address:	**City, State, Zip**

Does your receipt include the following?

Provider Name and Address ***Service Description*** ***Date of Service*** ***Patient Name*** ***Amount Billed***

For deductible expenses claims, please send a copy of the Explanation of Benefits (EOB) from your insurance carrier referencing the portion applied to the health plan deductible.

Credit card receipts and cashed checks are not a sufficient form of itemized documentation.

Check This Box if Paid w/ Flex Card	Date of Service	Patient Name	Relationship	Service Provider	Description of Service	Amount

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I am requesting reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan Participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I understand that the IRS regulates my benefit account and that these guidelines are implemented as a means of ensuring compliance and approval for reimbursement. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests, as doing so may delay payment. If this reimbursement request is for an Individual Coverage HRA (ICHRA), I attest that I, or my covered family member, had individual major medical coverage or Medicare in place at the time the claim was incurred. I authorize my Benefit Account balance to be reduced by the amount requested.

Employee Signature: _____ Date: _____

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