

HEALTH CARE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

PLAN YEAR 200____

SECTION A

ENROLLEE NAME				STREET ADDRESS					
SOCIAL SECURITY NUMBER	DAYTIME PHONE	AREA CODE	NUMBER	EXT.	CITY	STATE	ZIP CODE		

SECTION B

SUMMARY OF HEALTH CARE SPENDING ACCOUNT EXPENSES				DATES OF SERVICE ¹	
NAME OF PERSON RECEIVING SERVICES	RELATIONSHIP TO ENROLEE	NAME AND ADDRESS OF PROVIDER OF SERVICES ²	FROM MO/DAY/YR	TO MO/DAY/YR	AMOUNT TO BE REIMBURSED

TOTAL AMOUNT TO BE REIMBURSED \$ _____

¹ Use dates on which service was provided, **not** the date you paid for it.
² "Provider" means hospital, doctor, dentist, pharmacy, medical supply store, etc.

The above information is a true and accurate statement of unreimbursed medical expenses provided to me or my eligible dependents on the date(s) indicated. I have read and understand the information on the back of this form. I understand that I am responsible for misrepresentation regarding requests for reimbursement.

ENROLLEE SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY		
DATE	AUTHORIZATION #	INITIAL