

Debit Card Substantiation Request Form/Claim Form



☐ Please check here if this is a new mailing or email address

Employer Name (Please Print) _____

Employee Last Name (Please Print) _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone (_____) _____ Work Phone (_____) _____

Employee E-mail Address (if any) _____

Please read the Reimbursement Account Rules and Claim Filing Instructions provided online before completing this claim. All information below must be completed.

Medical Expense Claims

Debit Card Used in Transaction?	Date of Service	Patient Name	Relationship	Provider	Description of Service	Amount
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
☐ Yes ☐ No						\$
Total						\$

Employee's Certification for Reimbursement

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: ____/____/____
mm/dd/yy

For fastest reimbursement, please use the mobile app or email your account manager.

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