Health Care Spending Account Claim Form

Additional Pages

EMPLOYEE INFORMATION

LAST	FIRST	M.I.	SSN

THIS FORM MUST BE ACCOMPANIED BY A FILLED OUT AND AND SIGNED CLAIM FORM

SERVICE DATE	NAME OF SERVICE PROVIDER	NAME OF PERSON RECEIVING SERVICE	TYPE OF SERVICE OR EXPENSE	AMOUNT OF REIMBURSEMENT
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			TOTAL REIMBURSEMENT REQUESTED	$

Service Descriptions = Medical, Vision, Dental, Orthodontia, Prescription