DEPENDENT CARE FSA REIMBURSEMENT FORM

NUMBER OF PAGES FAXED:

PHONE NUMBER FOR QUESTIONS:

TO BE COMPLETED BY EMPLOYERR (Please complete all sections for prompt processing)

COMPANY NAME:

EMPLOYEE NAME: **(First, Middle, Last):**

EMPLOYEE ADDRESS:

EMPLOYEE SOCIAL SECURITY:	EMAIL ADDRESS:
NAME OF PATIENT:	RELATIONSHIP:
DATE OF SERVICE (MM/DD/YYYY):	DATE OF BIRTH (MM/DD/YYYY):

To the best of my knowledge and belief, my statements in the request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not been previously reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

EMPLOYEE SIGNATURE FOR VERIFICATION *(Required for processing submission)*

DATE (MM/DD/YYYY):

COMPLETE THIS SECTION IF YOU PROVIDE RECEIPTS

Reimbursement Reminders

1. You must complete the boxes in this section for each expense in order for your claim to be processed properly.
2. Your receipts must contain the following:
   - Date of Service
   - Type of Service
   - Amount of Service
   - Provider of Service
   - Social Security Number or Tax ID Number
3. Expenses must be totaled on each page
4. Copies of receipts for each expense claimed must be attached to the form

Date of Service	Provider	Type of Service	Amount of Service
			$
			$
			$
			$
			$
			$

COMPLETE THIS SECTION IF YOU DO NOT PROVIDE RECEIPTS

Reimbursement Reminders

1. You must complete the boxes in this section for each expense in order for your claim to be processed properly.
2. This completed reimbursement form serves as your receipt.

SIGNATURE OF DEPENDENT CARE PROVIDER: *(Required if receipts are not provided)*

x

DEPENDENT CARE PROVIDER'S NAME:

DATE OF SERVICE (MM/DD/YYYY):	SOCIAL SECURITY OR TAX ID#:	$

TOTAL DEPENDENT CARE EXPENSE: $

Return this completed reimbursement form and appropriate documentation. Please keep original receipts for your records as required by the IRS.

Complete and mail** to: **The HSAccess Card, 117 Seaboard Lane, F-125, Franklin, TN 37067**

Or Fax to: **(615) 401-9664**

HSAccess Card Customer Service Toll-Free Number: **(855) 863-6321**

***If mailing claims, please do not staple or tape receipts or EOB's to this form.*