HSAccess Card

HEALTH FSA REIMBURSEMENT FORM

NUMBER OF PAGES FAXED:

TO BE COMPLETED BY EMPLOYEE (Please Complete All Sections for Prompt Processing)

COMPANY NAME:

EMPLOYEE NAME (First, Middle, Last):

EMPLOYEE ADDRESS:

EMPLOYEE SOCIAL SECURITY (Last 4 digits only):

E-MAIL ADDRESS:

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)

STEP 1: Complete this section of the reimbursement form for eligible expenses incurred during your FSA plan year while you were a participant. Health Care expenses must be processed by your insurance company first. The insurance company will provide you with an Explanation of Benefits (EOB). An expense is incurred when the service is provided, not when you are billed or pay for the service.

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
   - Provider of Service
   - Name of Patient
   - Type of Service
   - Amount of Service
3. An Explanation of Benefits (EOB) from your insurance company or an itemized bill (receipt) is required to process this claim.
4. Copies of receipts for each expense claimed must be attached to the form.

Date of Service	Provider	Name of Patient	Type of Service	Amount of Service
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			TOTAL HEALTH CARE EXPENSE:	$ 0.00

STEP 2: Return this completed reimbursement form and appropriate documentation. Please keep original receipts for your records as required by the IRS.

Please complete this form and

- E-mail by going to **www.hsaccesscard.com**, OR
- Mail to: **HSAccess Card, 117 Seaboard Lane, F-125, Franklin, TN 37067** OR
- Fax to: **(615) 401-9664**

HSAccess Card Customer Care (855) 863-6321

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