###3T01413###################

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) REIMBURSEMENT FORM

INSTRUCTIONS

Send completed, signed form with all supporting documentation to:

Fax:
(855) 673-6716

or

Mail:
Spending Account Services
PO Box 162177
Altamonte Springs, Florida 32716

If you have any questions, call the number on the back of your Member ID Card.

ACCOUNT HOLDER INFORMATION *(*required fields)*

*Name:	*Member ID:
Address:	City, State Zip:
Email:	*Phone:

UNREIMBURSED HRA EXPENSES *(attach supporting documentation)*

Does your receipt include all of the following?
- Provider's name & address - Service description - Date of service - Patient's name - Amount billed

******CREDIT CARD RECEIPTS ARE NOT ACCEPTABLE******

Person for Whom Expense Was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Amount
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Total Unreimbursed HRA Expenses	**$**

ACCOUNT HOLDER AGREEMENT *(*required fields)*

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

_____ _____

*Account Holder Signature Date Signed