HealthSCOPE BENEFITS

HEALTH CARE & DEPENDENT CARE FUND REIMBURSEMENT REQUEST FORM

(Please Print Legibly)

EMPLOYEE INFORMATION

NAME:	SSN #:	DAY TIME PHONE #:
☐ CHECK HERE IF NEW ADDRESS	EMPLOYER NAME:	
ADDRESS:	EMAIL ADDRESS:	
CITY:	STATE:	ZIP:

REIMBURSABLE EXPENSES (Attach documentation)

DATE INCURRED	PROVIDER OF SERVICE (If Dependent Care service, must include SSN or ID number)	PERSON FOR WHOM SERVICE PROVIDED	EXPENSE TYPE *M or D	REIMBURSEMENT AMOUNT REQUESTED
				$
				$
				$
				$
				$
				$
				$
			TOTAL	$

* EXPENSE TYPE CODE: M = MEDICAL / D = DEPENDENT CARE

NOTE: See Item #5 on Claim Filing Instructions worksheet for Dependent Care requirements, available on the website shown below.

CERTIFICATION

I certify the following is true:

1. The expenses listed above were incurred by me and/or my eligible dependents and qualify for reimbursement. (See Claim Filing Instructions worksheet available on the website noted below.)
2. The expenses listed above are not eligible for reimbursement by any health care plan.
3. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
4. The appropriate bills, receipts, Explanation of Benefit statements or documentation for dependent care expenses are attached or verified by provider signature below.

Associate Signature **(REQUIRED)**:	Date:

Provider of dependent care certifying dates and amounts listed above are correct for services rendered.

Provider Signature:	Provider Tax ID:	Date:

Any person who knowingly and with intent to defraud or deceive any health care plan, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

FAX TO: (877) 240-0135

OR MAIL TO
HEALTHSCOPE BENEFITS, INC.
ATTN: FLEXIBLE SPENDING DEPARTMENT
P.O BOX 350
LITTLE ROCK, AR 72203

FOR MORE INFORMATION ABOUT YOUR ACCOUNT, PLEASE VISIT OUR WEBSITE:
www.healthscopebenefits.com

CUSTOMER SERVICE
1-877-385-8775