



**HEALTH CARE REIMBURSEMENT
REQUEST FORM**
(Please Print Legibly)

EMPLOYEE INFORMATION

NAME:	SSN #:	DAY TIME PHONE #:
<input type="checkbox"/> CHECK HERE IF NEW ADDRESS	EMPLOYER NAME:	
ADDRESS:	EMAIL ADDRESS:	
CITY:	STATE:	ZIP:

REIMBURSABLE EXPENSES (Attach documentation)

DATE INCURRED	PROVIDER OF SERVICE	PERSON FOR WHOM SERVICE PROVIDED		REIMBURSEMENT AMOUNT REQUESTED
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
TOTAL				\$

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.
The appropriate bills, receipts, or Explanation of Benefit are attached.

Employee Signature (REQUIRED):	Date:
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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: (501) 225-9153
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 CARE
1-877-385-8775**