

PARKING REIMBURSEMENT CLAIM
EMPLOYEE INFORMATION

NAME:	Last	First	MI
COMPANY:	El Paso County	PHONE:	

ADDRESS:		STATE	ZIP CODE
Social Security Number			

DATE OF SERVICE	PARKING FACILITY	\$ AMOUNT
TOTAL:		\$

I certify that the parking expenses and receipts submitted on this voucher for reimbursement were for my automobile to park either close to my business place or for parking space from which I commute by public transit, van or carpool. The parking space is not near my place of residence.

Signature

Date

HealthSCOPE Benefits
P. O. Box 350
Little Rock, AR 72203
Fax: 501-225-9153
Email: flexservices@healthscopebenefits.com

