



Flexible Spending Account Reimbursement Claim Form

Questions?
Contact us at:
(888) 436-0016
www.phtech.com

Employee Information

Employer Name: _____

Employee Name: _____

Employee Address: _____

Phone Number: _____

Reimbursement Request

Patient's Name	Relationship to Employee	Date of Service	Name of Provider	Expense Amount
1.				\$
2.				\$
3.				\$
4.				\$
5.				\$
6.				\$
TOTAL FOR THIS FORM				\$

You must attach appropriate documentation for each expense that clearly indicates: Provider Name, Patient Name, Date of Service, Type of Service and Expense Amount. The amount you request should be the amount you are actually responsible for after all insurance benefits are applied, if applicable. Appropriate documentation may include an Explanation of Benefits (EOB) from your health plan, Itemized Bill or Statement from your provider, or Copay Receipt. We cannot accept cancelled checks, credit card receipts, or money order receipts. Please attach and sign additional claim forms if needed.

Authorization

I certify that the information I have provided on this form is correct and complete. All expenses for which reimbursement is claimed have been incurred during the period of coverage for myself, my spouse or for an eligible dependent, as defined under Internal Revenue Code Section 152 (as amended by the Working Families Tax Relief Act of 2004). These expenses have not been reimbursed and I will not seek reimbursement for these expenses under any other plan covering health benefits. I understand that I cannot use expenses reimbursed through the healthcare account as tax deductions when filing income tax returns.

Employee Signature (required)

Date

Total number of pages faxed: _____

Please send claims to:
 PH Tech, PO Box 5308, Salem, OR 97304
 Email to fsa@phtech.com
 Fax to 503.315.4137
 Please visit us at our website at www.phtech.com.