Health Reimbursement Account Claim Form

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	$

Please remember to submit your Explanation of Benefits from your insurance company.

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.

_____ _____ Total number of pages faxed:____

Employee Signature (required) Date

Please send claims to:

PH Tech, PO Box 5308, Salem, OR 97304

Email to fsa@phtech.com

Fax to 503.315.4137