HEALTHCARE REIMBURSEMENT ACCOUNT

Reimbursement Claim Form

FAX: (877)587-4434 **E-Mail: nngg_cs@healthsmart.com**

Or, mail to: HealthSmart Benefit Solutions, PO Box 3262, Charleston, WV 25301

Company Name _____ Employee Social Security # _____

Name _____ **Change of address:** θ **Yes**

Street Address _____

City, State, Zip _____

Work Phone (area code) _____ **Home Phone (area code)** _____

HEALTH CARE EXPENSES -

Attach either of the following forms of supporting documentation as described below in order to be reimbursed:

- EOB (Explanation of Benefits) **–This is the form you receive each time your health care provider submit claims for payment to your medical, dental, or other health care insurance plan. The EOB will show the amount of the expenses paid or denied by the insurance plan and the amount you must pay.**
- **Itemized Receipts - (includes actual date expense was incurred*, name of provider, description of service, patient name, & cost) for copays or expenses not covered at all by your (or your spouse's) medical, dental, or other health care insurance plans.**
  **** Only expenses incurred in the current plan year are eligible for reimbursement.***

Date Expense Incurred	Name of Service Provider	Expense Description	Patient Name	Amount of Reimbursement Requested
/ /				$
/ /				$
/ /				$
/ /				$
		TOTAL		$

☐ **Additional Claim Forms are attached.**

**** EMPLOYEE SIGNATURE REQUIRED – READ CAREFULLY****

1. I certify that the above information is correct and that I have not received any reimbursement for these expenses from any other plan and the expenses are not reimbursable under any other source.
2. I may be liable for payment of all related taxes on the amounts paid for any expense improperly claimed under the plan.

_____ _____

Employee Signature Date