London Health Administrators, Ltd.

Please Mail Completed Form To:
London Health Administrators
40 Commercial Way
East Providence, RI 02914
Attn: Claims Department

Spending Account Reimbursement Claim Form

Employer Name:
Employee Name:
If Dependent, Name:
Phone:
Email:

Medical Expense Claims (HRA and/or FSA)

Account Type HRA - FSA		Date of Service	Provider Name	Provider Phone #	Service Provided	Amount Requested
				Total Amount Requested:		

Dependent Day Care Claims: (FSA Only)

Dependent Name	Date of Service From----To	Day Care Center	Day Care Center Phone #	Type of Service (Day Care, Pre-K, Day Camp, Etc.)	Amount Requested
	I				
	I				
	I				
	I				
	I				
			Total Amount Requested:		

Transportation Expense Claims (FSA Only))

Expense Type Parking---Transit	Date of Service From----To	Location	Mode of Transportation	Description of Expense (Mass Transit, Bus, Commuter, Etc)	Amount Requested
I	I				
I	I				
I	I				
I	I				
I	I				
			Total Amount Requested:		

I certify that the above information given by me in support of this claim is true and correct.

Date: Member's Signature:

For medical expenses, attach the original Explanation of Benefits (EOB) provided by your insurance carrier or receipt of payment for any medical expenses for which you are seeking reimbursement and send the information with this form to London Health Administrators, 40 Commercial Way, East Providence, RI 02914.

Timely filing: All requests for reimbursement must be submitted within 90 days of the date of service unless the London Health Administrators determines that unusual circumstances warrant a delay.

HRA ONLY - For Providers: The out-of-pocket expense for the employees of this company is being reimbursed by the employer. For any questions regarding this claim please call London Health Administrators at 1-800-343-2236 option #3.