# Health Care FSA
# Reimbursement Request Form

(DO NOT USE FOR HEALTH REIMBURSEMENT ACCOUNT (HRA) EXPENSES

Name _____ Last 4 digits of SS# _____

Mailing Address _____

City, State, ZIP _____ Is this a new address? ☐ **YES** ☐ **NO**

Daytime Phone Number _____ Email Address _____

| Patient Name | Relationship | Provider Name | Services | Date of Service | $ Amount |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Please submit documentation of your expense along with this form. Documentation may be an itemized receipt, a detailed bill from your provider or an explanation of benefits from your insurance company. The Internal Revenue Service requires that all documentation must contain the following information: (1) patient name (2) provider name (3) service received (4) date of service (5) transaction amount.**

**Submit this form and documentation to:**

**Fax** (904) 880-2830

**Mail** BenefitsWorkshop
P.O. Box 56828
Jacksonville, FL 32241

**Questions? Contact us!**

**Email** info@benefitsworkshop.com

**Phone** (888) 537-3539

**Website** www.benefitsworkshop.com/martincounty

I hereby certify that the information provided is correct and authorize the release of funds from the reimbursement account indicated above, if applicable. I understand that payment of these funds is made in accordance with the Plan provisions as governed by the Internal Revenue Code and that payment of these funds by the administrator is not a guarantee that the submitted expenses are eligible for reimbursement. I further certify that these expenses have not been reimbursed under this plan and are not reimbursable under any other plan that covers me or my dependents. I will retain a copy of this form and all original receipts for my records.

Signature _____ Date _____