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HSA / DCAP HEALTH SAVINGS ACCOUNT CLAIM FORM

NAME _____

SS# _____

ADDRESS _____

CITY, STATE ZIP _____

EMPLOYER _____

NOTE: Employer, please include the reimbursement amount on the time input sheet.

HEALTH CARE EXPENSES

Date of Service	Name of Medical Provider/Service	General Medical Expense Description	Name of care recipient & relationship to employee	Amount
Total Amount Requested:				

DEPENDENT CARE EXPENSES

Service must have already been provided to qualify for reimbursement.

Name of Dependent	Dependent's Relationship to Employee	Dependent's Birthdate	Dates of Service		Name & Address of Dependent Care Provider/ Service	EIN or Social Security Number of Provider	Amount
			From:	To:			
Total Amount Requested:							

By signing this form I certify that:

- All expenses listed above qualify for reimbursement,
- All expenses listed above have been incurred by me or by an eligible member of my family,
- All expenses listed above have not been reimbursed and are not reimbursable from another source,
- All expenses were incurred during the plan year period covered by the Flexible Spending Account Plan,
- All Dependent Care expenses were provided to a dependent under the age of 13 or for a dependent who is incapable of self-care,
- Attached to this form are bills, statements, or other qualifying evidence of expense.
- I understand the reimbursement amount will be on my pay check.

Employee Signature

Date