



Cafeteria Spending Account

Health Care Spending Account
Request for Reimbursement
Plan No. 501

Employee _____

Social Security # _____

(Please use this form to request reimbursement for expenses not covered by any Health Insurance or the unpaid balance of a health care claim)

Provider of Services	Person Receiving Services	Relationship	Date Expenses Incurred	For Office Use	Reimbursement Request Amount

Total Reimbursement Requested \$ _____

CLAIMS RECEIVED AFTER THE 20TH OF THE MONTH WILL BE PAID THE FOLLOWING MONTH.

I certify that:

1. The health care expenses claimed above are not eligible for reimbursement by any insurance carrier or employer sponsored health care plan.
2. The expenses claimed above have not been and will not be taken as a credit or deduction on my personal income tax return.

Date _____

Employee Signature _____

Instructions for Completing Claim Form

To prevent delays in processing your claim, Please complete this form correctly.

1. **Employee Name and Social Security Number:**
In the space provided, print or type your name as it appears on the payroll records and enter your correct Social Security Number.
2. **Provider of Services:**
Enter the name of the person or facility that provided the service; for example, the doctor or clinic. Use a separate line for each expense.
3. **Person Receiving Service:**
Enter your name, or if for a dependent, enter the dependent's name.
4. **Relationship:**
Enter the dependent's relationship to you; for example, spouse or child.
5. **Date Expense Incurred:**
Enter the date the expense was incurred, not the date it was paid.
6. **Reimbursement Request Amount:**
Enter the amount of the incurred expense that is eligible for reimbursement.
7. **Total Reimbursement Requested:**
Add amounts of reimbursement requested and enter the total.
8. **Date and Employee Signature:**
Enter the date and sign the form.
9. **Documentation Needed:**
You must attach copies of required documentation to receive reimbursement.
 - For expenses that must be submitted first to an insurance company or health care plan, attach a copy of the Explanation of Benefits form received from the insurance company or administrator.
 - For non-covered medical expenses such as physicals or eyeglasses, attach a statement of expense showing the type of service, the incurred date, and the amount of expense: for example, a physician's bill or pharmacist's prescription or receipt.
10. **Send completed form with documentation attached to:**

Aabakus, Inc. 750 Old Hickory Blvd. #170 - Brentwood, TN 37027.