FAX or EMAIL this form and receipts:

FAX: 866-635-1329

EMAIL: Flex@healthcomp.com

View claims status on www.HCHealthBenefits.com within 48 hours.

If you prefer to submit your form by mail,
Please send this form and receipts to:

HealthComp
P.O. Box 965
Covington, LA 70434
(PLEASE KEEP YOUR ORIGINALS)

HealthComp

Questions? Log on to www.HCHealthBenefits.com to view claims history, account balances and view receipts. Or call 800-547-0688

Use this form for FSA/HRA Claim Reimbursements

(Not for FSA/HRA Debit Card Receipts)

FSA/HRA CLAIM REIMBURSEMENT REQUEST FORM - Receipts received with this form will be processed for reimbursement

Employee Name _____ **Employee ID / SSN:** _____

Daytime Phone Number _____ **Email Address** _____

Employer Name _____

Health Care Reimbursement Claim (HCRA) - You MUST attach a bill, receipt or Explanation of Benefits (EOB) verifying the date of service or product, type of service or product, name of person receiving service and amount claimed.

	Date of Service	Type	For Whom (name and relationship)	Amount
1.				$
2.				$
3.				$
4.				$
5.				$

Use additional sheet(s) if necessary **TOTAL HEALTH CARE AMOUNT REQUESTED** $_____

Dependent Care Reimbursement Claim (DCRA) - You MUST attach a bill or receipt from your dependent care provider verifying the dependent's name, name, address and taxpayer ID number (SSN or TIN) of provider, period which services were rendered, description of services and amount. If the Dependent Care Provider signs the appropriate area below, receipts are not required.

	Date(s) of Service	Dependent's Name, Relationship and Date of Birth	Provider's Name and Address	Provider's Tax ID/SSN	Amount
1.					$
2.					$
3.					$

Use additional sheet(s) if necessary **TOTAL DEPENDENT CARE AMOUNT REQUESTED** $ _____

PROVIDER CERTIFICATION: I hereby certify that the above Dependent Care charges have been incurred.

Dependent Care Provider Signature _____ **Date** _____

I hereby certify that all items I requested to be reimbursed comply with the FSA/HRA Plan and such items have not and will not be covered by any other plan or program of any employer or other person nor have these items been paid for by a debit card or stored value card offered with the FSA/HRA Plan. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The company does not accept responsibility for direct payment to any individuals other than the employee.

Participant Signature X_____ Date _____