

REIMBURSEMENT FORM – HEALTHCARE EXPENSES

Use only CAPITAL LETTERS, completely fill in ovals,
and don't use red ink.

FAX TO: 1-866-643-2219 TOLL FREE

For additional expenses, please use next page.

XHXCXRX

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

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COMPANY NAME

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EMPLOYEE LAST NAME

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EMPLOYEE HOME ZIP CODE

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FOR WageWorks ONLY

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EMPLOYEE EMAIL

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DAYTIME PHONE # (AREA CODE FIRST, NO DASHES)

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SECTION 2: YOUR HEALTHCARE EXPENSES

EXPENSE 1

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

FROM

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TO

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REQUESTED AMOUNT (DOLLARS . CENTS)

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PATIENT DATE OF BIRTH (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO

EXPENSE 2

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

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REQUESTED AMOUNT (DOLLARS . CENTS)

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PATIENT DATE OF BIRTH (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO

EXPENSE 3

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

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REQUESTED AMOUNT (DOLLARS . CENTS)

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PATIENT DATE OF BIRTH (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO

SECTION 3: CERTIFICATION Please read Certification Statement thoroughly before signing.

I hereby certify that:

- I have read and understand the instructions on page one.
- The information contained within this form is correct.
- I have not received reimbursement previously for these expenses from my Healthcare Account or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with the IRS Definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free.
- Healthcare expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Healthcare Account. I hereby authorize WageWorks or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider claim for reimbursement under my Healthcare Account.

Date (MMDDYY)

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XHXCXRX

Employee Signature _____

SECTION 4: YOUR INFORMATION (ABBREVIATED)

SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES)

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EMPLOYEE LAST NAME

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EMPLOYEE HOME ZIP CODE

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SECTION 5: YOUR ADDITIONAL HEALTHCARE EXPENSES

EXPENSE 4

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

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REQUESTED AMOUNT (DOLLARS . CENTS)

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PATIENT DATE OF BIRTH (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO

EXPENSE 5

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

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REQUESTED AMOUNT (DOLLARS . CENTS)

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PATIENT DATE OF BIRTH (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO

EXPENSE 6

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

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REQUESTED AMOUNT (DOLLARS . CENTS)

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PATIENT DATE OF BIRTH (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO

EXPENSE 7

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO

EXPENSE 8

COVERAGE CODE (SEE PAGE 1)

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DATES OF SERVICE (MMDDYY)

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PATIENT DATE OF BIRTH (MMDDYY)

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COVERED BY INSURANCE?

YES NO

EOB ATTACHED?

YES NO