



**PERSONAL INFORMATION:**

Last Name:  First Name:   
 ID Number:  Phone Number:   
 Name of Employer:

**REIMBURSEMENT INFORMATION:**

	Service Dates:		Provider Name:	Type of Service*:	Reimbursement Requested:
	From:	To:			
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Attach **COPY** of itemized receipts.

**TOTAL:**

\* Be specific with the type of service. Examples include copay, glasses, orthodontics, mileage, and over-the-counter item names.

Dual-purpose claims must include documentation showing the medical practitioner's diagnosis and treatment recommendation.

I certify that the expenses for which I am requesting reimbursement meet all the conditions listed below:

- They were incurred for services or supplies received by my eligible dependents or me under the plan.
- They were for services or supplies furnished on or after the effective date of my employee reimbursement account.
- I have not been reimbursed for these expenses in any other way or from any other source.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered.

**Health Savings Account (HSA) Owners Only:**

I understand that (1) I may not submit any expense that would apply toward the deductible of my high deductible health plan (HDHP) and (2) that I will be limited to reimbursement for dental and vision expenses only through my flexible spending account (FSA) until the deductible of my HDHP has been met. Once the deductible for my HDHP has been met, I may then submit any expense that is eligible in accordance with my flexible spending account plan document.

I further certify that I have not deducted nor will I deduct on my individual tax return any of the expenses reimbursed through my health care reimbursement account. I understand that reimbursement will be made in accordance with the provisions of my benefit plan(s). I accept sole responsibility for the proper treatment of benefits paid under this plan and other applicable plans with respect to eligibility, income tax reporting and liability. Fiserv Health shall not be liable for any penalties or damages as a result of an ineligible claim filed by me. I will retain a copy of this form and all original receipts for my records. I understand that submitting false claim information could lead to termination of employment, potential prosecution, and possible implications with the Internal Revenue Service (IRS).

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**FAX TO:** 877-390-4782 (toll-free) or 715-841-7049  
**SEND TO:** Fiserv Health • MS 6230, Claim Services • P.O. Box 8022 • Wausau, WI • 54402-8022  
**INQUIRIES:** www.fiservhealthservices.com or 1-800-826-9781 ext. 2189

*The deadline for filing current year claims for reimbursement is 90 days after the end of the plan year unless otherwise specified in your Plan Document.*