Health Reimbursement Account Expense Documentation

Name _____ Last 4 digits of SS# _____

Mailing Address _____

City, State, ZIP _____ Is this a new address? ☐ **YES** ☐ **NO**

Daytime Phone Number _____ Email Address _____

Patient Name	Relationship	Provider Name	Services	Date of Service	$ Amount

To be considered for reimbursement, you must submit a copy of the Explanation of Benefits (EOB) from your insurance company with this form.

Submit this form and documentation to:

Fax (904) 880-2830

Mail BenefitsWorkshop
P.O. Box 56828
Jacksonville, FL 32241

Questions? Contact us!

Email info@benefitsworkshop.com

Phone (888) 537-3539

Website www.benefitsworkshop.com/employeeinfo

I hereby certify that the information provided is correct and authorize the release of funds from the reimbursement account indicated above, if applicable. I understand that payment of these funds is made in accordance with the Plan provisions as governed by the Internal Revenue Code and that payment of these funds by the administrator is not a guarantee that the submitted expenses are eligible for reimbursement. I further certify that these expenses have not been reimbursed under this plan and are not reimbursable under any other plan that covers me or my dependents. I will retain a copy of this form and all original receipts for my records.

Signature _____ Date _____