Health Care Expense Documentation

Name _____ Last 4 digits of SS# _____

Address _____ Is this a new address? ☐ **YES** ☐ **NO**

City, State, ZIP _____

Phone _____ Email _____

Please choose one:

☐ **I am providing documentation for the transaction(s) listed below.** I paid for these expenses using my BenefitsWorkshop Debit Card and do not need to be reimbursed for these amounts.

☐ **I am requesting reimbursement of the transaction(s) listed below.** I paid for these expenses out-of-pocket and need to be reimbursed for these amounts.

Patient Name	Relationship	Provider Name	Services	Date of Service	$ Amount

Please submit documentation of your expense along with this form. Documentation may be an itemized receipt, a detailed bill from your provider or an explanation of benefits from your insurance company. The Internal Revenue Service requires that all documentation must contain the following information: (1) patient name (2) provider name (3) service received (4) date of service (5) transaction amount.

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 benefitsworkshop.com/oaklandpark

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 _____