

Spending Account Reimbursement Claim Form

Employer Name:
Employee Name:
If Dependent, Name:
Phone:
Employee ID #:

Health Care Expense Claims: (HRA, HSA and/or FSA)							
Account Type			Date of Service	Provider Name	Provider Phone #	Service Provided	Amount Requested
HRA	HSA	FSA					
Total Amount Requested:							

Dependent Day Care Claims: (FSA Only)						
Dependent Name	Date of Service		Day Care Center	Day Care Center Phone #	Type of Service <small>(Day Care, Pre-K, Day Camp, Etc.)</small>	Amount Requested
	From	To				
Total Amount Requested:						

Transportation Expense Claims: (FSA Only)						
Expense Type <small>Parking---Transit</small>	Date of Service		Location	Mode of Transportation	Description of Expense <small>(Mass Transit, Bus, Commuter, Etc)</small>	Amount Requested
	From	To				
Total Amount Requested:						

I certify that the above information given by me in support of this claim is true and correct.

Member's Signature: _____

Date: _____

Please Send Completed Form With Receipts To:

CDH Administration
40 Commercial Way, E. Providence, RI 02914
Email: BCBSRIclaims@londonhealthusa.com
Fax: 401-435-3937

For Questions please call:

Local: 401-459-5000
Out of State: 1-800-639-2227

Plan Administrator: London Health Administrators

Timely filing: All reimbursement requests must be sent within 90 days of the service date unless London Health determines that unusual circumstances warrant a delay.