STREAMLINE HR
AUTOMATING HR, PAYROLL & BENEFITS

Health Care FSA Claim Form

Employee Information			
Employer:			
Name (First, Middle, Last):			Employee ID or last 4 digits of SSN:
Street Address:			
City:	State:	Zip:	Daytime Phone Number:
Email:			

List of Healthcare Spending Account Expenses for Reimbursement
(Please provide corresponding itemized bills, receipts or insurance carrier's Explanation of Benefits)

Date of Service	Family Member	Description of Service	Physician or Provider Name	Amount Requested
			Total Amount Requested:	

Employee Statement

I certify that the expenses listed above have been incurred during the applicable plan year by myself and/or my eligible dependent(s) and qualify for reimbursement. I am certifying that the expenses listed above have not been previously reimbursed, nor will they be under any other benefit plan and will not be claimed as an income tax deduction. If there is a discrepancy between the total amount requested above and the total amount of the attached supporting documentation, I will only be reimbursed according to the total amount of eligible expenses on the attached supporting documentation.

_____ _____

Employee's Signature Date

Please return claim form and supporting documentation by emailing, faxing or mailing to:
Streamline HR - Attn: Spending Accounts - 5920 Hamilton Boulevard, Suite 201 - Allentown, PA 18106 –
Phone: (877) 262-7291 - Fax: (877) 385-7926 - spendingaccounts@mystreamlinehr.com

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Requirements for Filling a Claim:

1. Complete the **Employee Information** section of the claim form.

2. Complete the **List of Expenses for Reimbursement** section of the claim form and attach all supporting documentation.
    - Please make sure to include one or both of the following forms of acceptable supporting documentation:
        - **Fully Itemized Bill –** including service date(s), claimant's name, service type(s) and the amount of the service(s) from the provider or merchant that shows any third-party payment made.
        - **Explanation of Benefits (EOB) –** including deductible, co-insurance and ineligible amounts that would not be covered by a health plan that you and/or your eligible dependents are covered by.

3. Please sign and date the **Employee Statement** section of the claim form.

4. Please make sure to retain a copy of the claim form as well as all supporting documentation you are submitting. This information will not be returned to you.

5. Mail, Fax or email your fully completed Health Reimbursement Arrangement claim form and supporting documentation to:

    - **Fax:** (484) 661-4778

    - **Email:** spendingaccounts@mystreamlinehr.com

    - **Mail:**

        - Streamline HR
          Attn: Spending Account Claims Processing
          5920 Hamilton Boulevard
          Suite 201
          Allentown, PA 18106

For any questions or inquiries regarding your Health Care Spending Account claim submission or account, please contact us at (877) 262-7291 or spendingaccounts@mystreamlinehr.com