

Spending Account Reimbursement Claim Form

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

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

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

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

London Health Administrators
40 Commercial Way, E. Providence, RI 02914
Email: dedicated@londonhealthusa.com
Fax: 401-435-3937

For Questions please call:

Local: 401-435-4700
Out of State: 1-800-343-2236

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.