

## Spending Account Reimbursement Claim Form

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

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

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

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

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](mailto:dedicated@londonhealthusa.com)  
Fax: 401-435-3937

**For Questions please call:**  
Local: 401-435-4700  
Out of State: 1-800-343-2236