



**ICUBA – FLORIDA INSTITUTE OF TECHNOLOGY
HRA - HEALTH REIMBURSEMENT
REQUEST FORM**

Name	SS#	Mail or fax claims to: OutsourceOne P.O. Box 616927 Orlando, FL 32861-6927 Toll-free phone: 866-377-5102 Toll-free fax: 866-377-5180 Email: flex@icuba.org
Home Address	Address Change <input type="checkbox"/> Yes <input type="checkbox"/> No	
City	State Zip	
Phone: Work Home	e-mail	

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete it will be returned to you. Print or type the information requested, then sign and date the form. Mail, fax or email this form and supporting documentation to OutsourceOne.

**HRA
HEALTH CARE EXPENSES (Medical, Dental, Vision)**

	Provider of Service (Doctor, dentist, pharmacy, etc.)	Person Receiving Service (self, spouse, child)	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1				\$	
2				\$	
3				\$	
4				\$	
5				\$	
6				\$	
7				\$	
8				\$	
9				\$	
10				\$	

I request payment from my health reimbursement account as indicated above for the expenses listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I authorize my Health Reimbursement Account to reimburse me by the amount requested.

Employee Signature _____ Date _____

PLEASE SEE REVERSE SIDE FOR FILING INSTRUCTIONS

INSTRUCTIONS FOR COMPLETION OF HEALTH REIMBURSEMENT SPENDING CLAIM FORMS

HRA

HEALTH CARE EXPENSES (Medical, Dental, Vision)

- Complete claim form – all requested information must be provided or claim will be denied.
- Attach originals or copies of medical bills, insurance explanation of benefits, prescription drug receipts, cash register receipts, etc. The documentation must provide the following information or the claim will be denied:
 1. Name of provider of service (doctor, dentist, pharmacy, etc.)
 2. Name of person receiving service (self, spouse, dependent)
 3. Date of service
 4. Explanation of procedure
 5. Cost of procedure less any amounts paid by primary insurance provider

Mail, fax or email completed claim form and documentation to:

OUTSOURCE ONE, INC.
P.O. Box 616927
Orlando, FL 32861-6927
Toll-free fax: 866-377-5180
Email: flex@icuba.org