Mobile Upload
Electronic Claim submission:
https://secure.ebpabenefits.com
Fax: 603-773-4415
Mail To: EBPA Reimbursement Accounts
P.O. Box 1140
Exeter, NH 03833-1140
Phone: 888-678-3457

REIMBURSEMENT REQUEST FORM

NAME	SOCIAL SECURITY NUMBER (OPTIONAL)
ADDRESS (STREET)	EMPLOYER:
ADDRESS (CITY, STATE, ZIP CODE)	LOCATION/DIVISION

HEALTH CARE ACCOUNT

- List reimbursable expense and attach explanation of benefits or itemized bill.
- Identify each expense as M (Medical), D (Dental), V (Vision), H (Hearing), or O (Other), under Type of Expense.
- If an expense is covered in part by a health plan the balance may be submitted for reimbursement only after all health plan benefits from all sources have been paid. A copy of the health plan's payment voucher or denial must be submitted with the claim. If no health plan applies write "none" in the Plan payment column.
- Attach a second form if you need additional space.

TYPE OF EXPENSE	EXPENSE FOR: FIRST NAME		RELATIONSHIP	DATES OF SERVICE: FROM	TO	TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT OF REIMBURSEMENT DUE
				TOTALS				

DEPENDENT CARE ACCOUNT

- You must have an itemized bill (or have the provider sign this form) and the taxpayer ID Number from each person providing care.
- List each dependent receiving care on a separate line. List each provider on a separate line.
- Attach the appropriate documentation information.

DEPENDENT'S FULL NAME	AGE	RELATIONSHIP	DATES OF CARE: FROM:	TO	NAME OF PROVIDER OF CARE	AMOUNT (ATTACH PROOF OF EXPENSE INCURRED)
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
					TOTAL	

1. certify that the above listed expenses have been incurred by me or my eligible dependents (as defined by the IRS).
2. I certify that all applicable insurance or other health benefits have been exhausted.
3. I certify that I will not deduct or take as a tax credit on my Federal Income Tax Return these reimbursements.
4. I will assume all responsibility for taxes or penalties arising out of any disallowed deductions.
5. I have received the taxpayer ID # of my care provider.

ALL DISBURSEMENTS FROM THE REIMBURSEMENT ACCOUNTS WILL BE MADE PAYABLE TO THE EMPLOYEE.

SIGNATURE _____ DATE:_____

SIGNATURE OF CARE PROVIDER _____ DATE:_____