



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:			DATES OF SERVICE:		TOTAL BILL (ATTACH COPY)	PLAN PAYMENT (ATTACH PAYMENT OR DENIAL)	AMOUNT OF REIMBURSEMENT DUE	
	FIRST NAME		RELATIONSHIP	FROM	TO				
<b>TOTALS</b>									

#### 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:		NAME OF PROVIDER OF CARE	AMOUNT (ATTACH PROOF OF EXPENSE INCURRED)
			FROM:	TO		
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
FEDERAL TAXPAYER ID # OR SOCIAL SECURITY # OF PROVIDER:						
<b>TOTAL</b>						

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: \_\_\_\_\_