HRC TOTAL SOLUTIONS

FSA·HRA·HSA·COMMUTER·COBRA·LSA·ICHRA

UNIVERSAL CLAIM FORM

First Name:	Last Name:	Last 4 Digits of SSN:
Phone:	Email Address:	
Mailing Address Line 1:		
Mailing Address Line 2:		
City:	State:	Zip:
Employer:	Related Case # (if applicable):	

CLAIMS CODES

F Health Care FSA	**L** Limited Purpose FSA	**H** HRA	**HF** HRA, then FSA	**LS** Lifestyle Spending LSA
D Dependent Care FSA	**A** Apply to Repayment	**P** Parking	**S** Substantiation Debit Card	

ENTER ONLY ONE CLAIM CODE PER DETAIL SECTION

Claim Code	Start Date of Service	End Date of Service	Provider Name
	Description of Service		Claim Amount
	Person Receiving Service	Tax ID *(Dependent Care FSA Only)*	Day Care Provider Signature *(Dependent Care FSA Only)*
Claim Code	Start Date of Service	End Date of Service	Provider Name
	Description of Service		Claim Amount
	Person Receiving Service	Tax ID *(Dependent Care FSA Only)*	Day Care Provider Signature *(Dependent Care FSA Only)*
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		CLAIM TOTAL $	

The above statements and submitted information for reimbursement are true. I am only submitting for reimbursement for eligible expenses that I incurred for myself or legal dependents. I certify that I have not been nor will I be reimbursed for these submitted reimbursements from any other source. I further certify that I will not claim these expenses as a tax deduction.

Employee Signature	Date:

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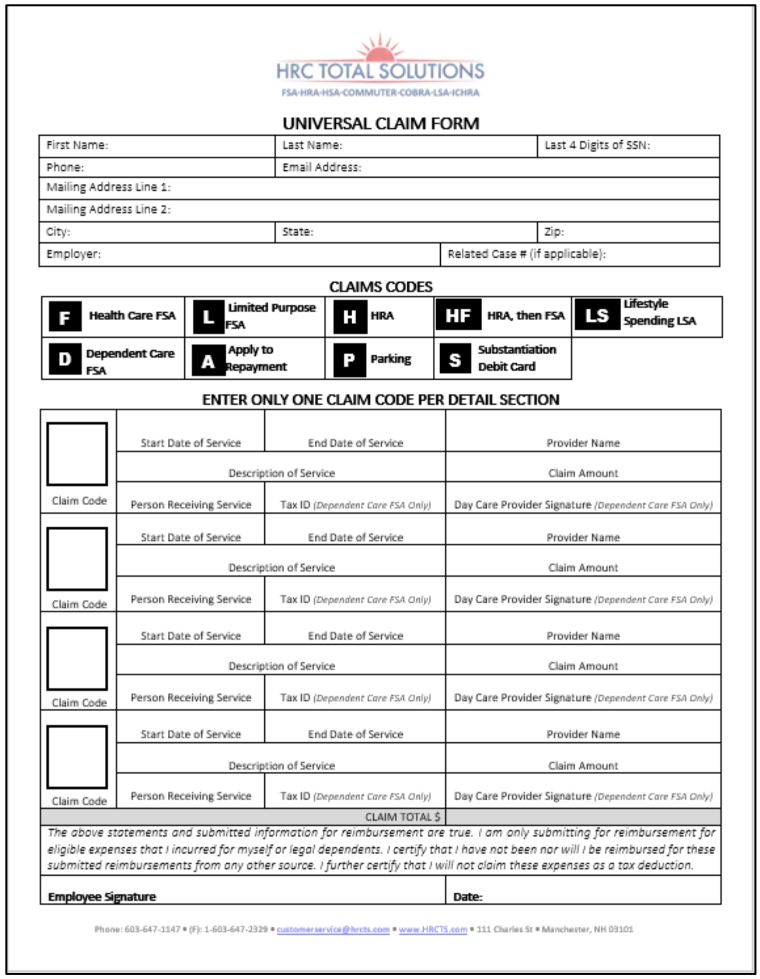
HOW TO COMPLETE CLAIM FORM

1. Complete the Employee Information section. Be sure to include the last 4 digits of your SSN and your email address.
2. Review the Claim Codes.
   Enter Claim Code that corresponds with your plan into the box.
   - [F] Health Care FSA
   - [L] Limited Purpose FSA
   - [D] Dependent Care FSA
   - [H] HRA
   - [HF] HRA first, then FSA
   - [S] Substantiation - Debit Card
   - [P] Parking
   - [AR] Apply to Repayment
   - [LS] Lifestyle Spending LSA
3. Complete the Claims Section.
4. Sign and date the claim form.



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Mailing Address Line 1:		
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Employee Signature **Date:**

Phone: 603-647-1147 • (F): 1-603-647-2329 • customerservice@hrcts.com • www.HRCTS.com • 111 Charles St • Manchester, NH 03101

IMPORTANT NOTES FOR CLAIM SUBMISSION

1. Claims will be processed the same day if received by 10:00am EST
2. Please allow 3 business days from the day you submit your claim form before viewing the status on your Participant Portal.
3. Remember to send appropriate claim documentation in with your form to substantiate the expenses you are submitting for reimbursements. Claim documentation must include the provider name, the dates(s) of service, a description of the expenses incurred and the expense amount. **Cancelled checks and non-itemized credit card receipts are not valid forms of documentation.**
4. Retain original copies of the claim form and expense documentation for your files; Claim Forms, receipts and claims information will not be returned.
5. Refer to your company or Summary Plan Description for the length of your run out period, which determines the number of days you have after the plan year ends to submit claims.
6. When submitting claims for your HRA Expenses: please claim the full eligible deductible amount shown on your Explanation of Benefits or receipt. We will automatically make any calculations necessary in accordance with your plan design. You must submit an Explanation of Benefits (EOB) and not a bill from your provider for HRA expenses.

PLEASE SUBMIT CLAIM FORM TO CUSTOMER SERVICE

Monday – Friday 8: 30am-5:00pm EST

(603) 647-1147 Option 1 (603) 647-2329 customerservice@hrcts.com