Capital BLUE

Flexible Spending Account (FSA),
Health Reimbursement Arrangements (HRA),
and Medical Expense Reimbursement Plan (MERP)

capbluecross.com

Reimbursement Voucher

Section I — Subscriber Information

Identification Number:		**Group Name:**	
Subscriber Name:	First	Middle	Last
Subscriber Mailing Address:	Street		
City		State	ZIP Code

Section II — Subscriber Certification

I certify that the attached charges are eligible expenses under the internal revenue code (irs.gov/publications/p502/index.html), these charges have been incurred, and I have not been reimbursed by any other source for these charges. I also certify that they will not be claimed as a deduction on my personal income tax return.

I certify that I either have no coverage for the expenses listed below or that they are ineligible under my current medical plan:

Subscriber Signature _____ Date Of Signature _____

Section III* — Medical/Dependent Care Expenses

Date Of Service	Provider Tax ID (Dependent Care Only—IRS Requirement)	Provider Name	Expense Description	Patient/Dependent Name	Amount To Be Reimbursed

***This area must be completed; attachment of receipts alone is not sufficient.** **TOTAL**

Section IV — Instructions

NOTE: MISSING INFORMATION WILL DELAY THE PROCESSING OF CLAIMS.

1. Complete Section I "Subscriber Information" in full.
2. Complete Section II. Your signature certifies that the expenses for which you are requesting reimbursement are eligible medical care expenses under the Internal Revenue Code and will not be claimed as an income tax deduction. You are also certifying that you will not be reimbursed under any other coverage or insurance.
3. Complete Section III including the provider of services, the dates of service, the amount you wish to be reimbursed, and the patient's name. The service date will determine the Flexible Spending year of your claim. Use different forms for different years.
4. You must attach your itemized receipt of bill and/or Explanation of Benefits for reimbursement. **Credit card receipts do not contain sufficient evidence of date of service or services provided to fulfill IRS requirements.**
5. Send completed form to: **P.O. Box 772402, Harrisburg, PA 17177-2402, fax to 866.682.2242, or email a scanned copy to FSAClaims@capbluecross.com**. **If you have any questions, contact us by calling the Customer Service telephone number located on the back of your identification card.**

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