

**Reimbursement Request
Health Care Spending Account**

AUDITOR'S USE ONLY
Date Received: _____

Employee name: _____

Personnel number: _____

Current Mailing Address: (Check this box **ONLY** if this address differs from the address on file in the Auditor/Controller's Office)

Note: See the back of this form for instructions on how to complete the information below and a description of the bills or other information which must be submitted with your request.

Summary of Expenses					
Name of person receiving service or supplies	Relationship to employee	Provider of service or supplies	Type of expense	Date of service	Amount to be reimbursed

I certify that, to the best of my knowledge, the above information is accurate and that payment is being requested only for expenses of eligible parties (self, spouse, or tax deductible dependents). I am requesting

payment only for expenses which have not and will not be paid by any insurance plan. I understand that any expenses reimbursed from this account are not tax deductible on my federal income tax return.

Employee signature: _____

Date: _____

Auditor-Controller - Green

Employee - White

Your Reimbursement Request Form Health Care Spending Account

Filling out the form

Complete all sections of the form. This form cannot be saved electronically with Adobe Acrobat Reader, you must print the form and then sign and date it.

- 1) Submit only expenses which are reimbursable under the Health Care Spending Account. These include expenses not paid by any medical or dental insurance plan. Eligible expenses include:
 - deductibles (your front-end medical and dental costs)
 - co-insurance (your share of the medical and dental expenses)
 - routine physical examinations
 - deductibles and co-payments for eyeglasses, contact lenses, hearing aids plus the cost of exams associated with their prescription
 - any healthcare service or supply which you could *otherwise* use as a tax deduction (Insurance premiums for any health insurance other than your employer's, are not reimbursable)
- 2) **Name of person receiving service or supplies** – Enter the first and last name of the person whose expenses are being submitted for reimbursement.
- 3) **Relationship to employee** – Indicate self, spouse, son, daughter, or other dependent that would be eligible under your health care spending account.
- 4) **Provider of services or supplies** – Enter the name of the doctor, dentist, ophthalmologist, hospital, clinic, pharmacy, etc.
- 5) **Type of expense** – Enter a description of the service or supplies for which reimbursement is requested, such as routine physical, dental work, eye examination, eyeglasses, contacts, prescribed drugs, doctor visit for flu, a certain surgical procedure, etc.

- 6) **Date of service** – Enter date on which service or supplies were received. This date must occur during your participation in the plan.
- 7) **Amount to be reimbursed** – Enter the amount to be reimbursed from your account. This amount should include only that portion of the expense that was not eligible for payment by any insurance plan.
- 8) **Total** – Enter the total amount of reimbursement you are requesting.

Attaching your bills and records

When you submit your request for reimbursement you must also provide copies of itemized bills or receipts that clearly state each of the services and supplies provided including:

- name of person or organization providing the service or supplies
- name of the person receiving the service or supplies
- date that service or supplies were provided
- total charge for the service or supplies
- description of the service or supplies – bill for prescription drugs must include prescription number, date of purchase, and name of prescribing physician. Over-the-counter medicines and drugs require a prescription to be considered an eligible expense.

Note: Canceled checks are not acceptable receipts

Termination of Participation: Once you terminate participation in the plan you may not re-enroll during the same plan year. You may continue to file claims only for expenses incurred prior to your termination of participation. **Claims must be submitted no later than 60 days after termination of your participation in the plan.**

Submitting your request: Send the original copy of your completed form and copies of your bills to the Auditor/Controller's Office, Room D220, County Government Center, San Luis Obispo, CA 93408. If you have any questions about how to complete this form, what bills to submit, or about your Health Care Spending Account, contact 781-5034 or 781-5007.