REIMBURSEMENT REQUEST FORM

INSTRUCTIONS

Mail form and documentation to: TPSC - Attn: FSA/HRA Department, P.O. BOX 1894, Tacoma, WA 98401-1894
Deliver completed form and documentation to: TPSC, 1101 Pacific Ave, Suite 300, Tacoma, WA 98402
Fax completed form and documentation to: 253.564.5881
Upload completed form and documentation at: www.tpscbenefits.com
Customer Service Line: 253.564.5611, Ext. 210 or toll-free 1.800.426.9786, Ext. 210

EMPLOYEE STATEMENT

Last Name:	First Name:	M.I.:	
Birth Date:	Social Security #:		
Address:	☐ Check if New Address		
City:	State:	Zip:	Phone #:
Date of Hire:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married	
Name of Employer:	Group #:		
Duties:			

HEALTH CARE FSA REQUEST	DATE(S)	PROVIDER	PATIENT	AMOUNT
• You must attach a copy of the itemized provider's billing and/or insurance company's "Explanation of Benefits" verifying the dates of service, patient name, cost, and all payments made by insurance contracts, to this form. • **Do not staple any documentation to reimbursement form, please tape to separate sheet or include loosely in envelope. Do not send originals (all reimbursements are stored electronically and paper copies will be shredded).**				$
				$
				$
				$
				$
				$

DEPENDENT CARE FSA REQUEST	DATE(S)	PROVIDER	CHILD(REN)	AMOUNT
• You must attach a copy of the provider's bill or a receipt verifying the names and birthdates of the children receiving care, the name of the care provider, the provider's Tax ID or Social Security Number and signature, the date(s) of service and cost, for ALL requests, to this form.	From: To:			$
	From: To:			$
	From: To:			$

HRA REQUEST	DATE(S)	PROVIDER	PATIENT	AMOUNT
• You must attach a copy of the itemized provider's billing and/or insurance company's "Explanation of Benefits" verifying the dates of service, patient name, cost, and all payments made by insurance contracts, to this form. • **Do not staple any documentation to reimbursement form, please tape to separate sheet or include loosely in envelope. Do not send originals (all reimbursements are stored electronically and paper copies will be shredded).**				$
				$
				$
				$

To the best of my knowledge and belief, my statements on this reimbursement request form are complete and true. I understand that I am solely responsible for the validity of claims submitted to my FSA and/or HRA Account. I am claiming reimbursement only for eligible expenses incurred by me and my eligible tax dependents and certify that these expenses have not been reimbursed under this plan or by any other source and that they are not eligible to be reimbursed by any other source or insurance. **By providing my email address, I am requesting that all possible communications regarding this claim may be sent via email.**

Email Address:

Signature

Date

MILEAGE WORKSHEET

INSTRUCTIONS

Enter your information in the appropriate columns below.

TPSC Benefits Claims Administrator:
P.O. Box 1894; Tacoma, WA 98401

Phone: 253.564.5611 ext. 210
Fax: 253.564.5881
Toll Free: 800.426.9786 ext. 210

DATE	PROVIDER NAME & ADDRESS	TYPE OF SERVICE (MEDICAL, DENTAL, VISION PRESCRIPTION)	NUMBER OF MILES TRAVELED (X) MILEAGE RATE	TOTAL COST
			X	
			X	
			X	
			X	
			X	
			X	
			X	
			X	

DATE	PROVIDER NAME & ADDRESS	TYPE OF SERVICE (MEDICAL, DENTAL, VISION PRESCRIPTION)	PARKING COST	TOTAL COST
			Total Reimbursement Requested	

CERTIFICATION AND AUTHORIZATION: To the best of my knowledge and belief, my statements on this reimbursement request form are complete and true. I understand that I am solely responsible for the validity of claims submitted to my FSA Accounts. I am claiming reimbursement only for eligible expenses incurred by me and my eligible tax dependents during the Current Plan Year and any grace period (if applicable) and certify that these expenses have not been reimbursed under this plan or by any other source and that they are not eligible to be reimbursed by any other source or insurance. By providing my email address, I am authorizing that all possible communications regarding this claim may be sent via email. I hereby authorize my FSA Accounts to be reduced by the amount(s) shown above.

Signature

Date