HCA Claim Form

Health Care Spending Account

Employee Information:

Employee Name:
First/Last

Last Four Digits of SSN:

Primary Phone:

Employer:

Email Address:

Email is required to receive important account noti cations such as claim con rmations, payment noti cations and denial letters.

Health Care Reimbursement Expenses			
Amount to be Reimbursed	Service Date MM/DD/YYYY	Description of Product/Service	Person Receiving Product/Service
$			
$			
$			
$			
$	Total Expenses Requested