



**Employee Information**

For timely and accurate processing, please complete entire form

**Last 4 Digits of SSN (Required)** **Phone Number**

**First Name** **Last Name** **Plan Year**

**Email Address** **Employer Name**

**Claims Codes:**

**F** Health Care FSA **L** Lim. Purpose FSA **D** Dependent Care FSA **H** HRA **HF** HRA, then FSA **R** Receipts - Debit Card **P** Parking

Enter only one Claim Code per detail section

<input type="text"/>	<input type="text"/> Date of Service	<input type="text"/> Provider	<input type="text"/> Person Receiving Service (Required for HRA)
Claim Code	<input type="text"/> Description of Service	<input type="text"/> Tax ID (Dependent Care FSA only)	<input type="text"/> Claim Amount
	<input type="text"/> Daycare Provider Signature (Dependent Care FSA only)		
<input type="text"/>	<input type="text"/> Date of Service	<input type="text"/> Provider	<input type="text"/> Person Receiving Service (Required for HRA)
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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**

## 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 Claims
  - [ L ] Limited Purpose FSA
  - [ D ] Dependent Care FSA
  - [ H ] HRA
  - [ HF ] HRA first, then FSA
  - [ R ] Receipts - Debit Card
  - [ P ] Parking
3. Complete the Claims Section.
4. Sign and date the claim form.

## 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.
7. Parking Claims must be submitted within 180 days of the date of service and within 90 days of the plan year end.


## Mobile Apps & SMS Text Alerts

Save time and hassles while you make the most of your Parking, HSA, HRA, and FSA accounts by checking your balances, submitting a claim, and taking a picture of your receipt on your [Android](#) or [iOS](#) device. No more losing receipts! Find our mobile app on the Google Play store or on iTunes.

SMS text message alerts are available for all mobile devices on AT&T, Nextel, Sprint, Verizon, and T-Mobile networks! You can opt in/out via the [Participant Portal](#) and configure which alerts you prefer to receive.

**Customer Service Call Center Hours:**  
 Monday – Friday 8:30am-7:30pm ET  
 Live Chat: <http://hrcts.com>

Phone: (603) 647-1147 option 1  
 Fax: (866) 978-7868  
 Email: [customerservice@hrcts.com](mailto:customerservice@hrcts.com)



**Employee Information** 1

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Last 4 Digits of SSN (Required)      Phone Number  
 First Name      Last Name      Plan Year  
 Email Address      Employer Name

**Claims Codes:**

Health Care FSA      Lim. Purp     2  Dependent Care FSA      HRA      HF HRA, then FSA      Receipts - Debit Card      Parking

Enter only one Claim Code per detail section

<input type="checkbox"/>	Date of Service	Provider	Person Receiving Service (Required for HRA)
Claim Code	Description of Service		Claim Amount
	Tax ID (Dependent Care FSA only)		Daycare Provider Signature (Dependent Care FSA only)

3

<input type="checkbox"/>	Date of Service	Provider	Person Receiving Service (Required for HRA)
Claim Code	Description of Service		Claim Amount
	Tax ID (Dependent Care FSA only)		Daycare Provider Signature (Dependent Care FSA only)

4

Claim Total: \$

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