

SelectAccountSM

MEDICAL EXPENSE REIMBURSEMENT ACCOUNT CLAIM FORM

☐ If this is a resubmission ☐ If new address

Use this form for eligible expenses incurred by you or your eligible dependents.

Complete when faxing: # of pages _____
To expedite reimbursement, fax this form and supporting documentation to 1-866-231-0214. This form serves as the cover page.

SECTION A – Account Holder Information (PLEASE PRINT)

ACCOUNT HOLDER'S NAME	LAST	FIRST	MIDDLE	SELECTACCOUNT ID#
				S A
STREET ADDRESS				SOCIAL SECURITY # (if SA# not known)
CITY		STATE	ZIP CODE	DAYTIME PHONE NUMBER
ACCOUNT HOLDER EMAIL ADDRESS			EMPLOYER NAME	

SECTION B – Claim Detail (PLEASE PRINT)

All fields in this section must be completed. If information is missing, the processing of your claim may be delayed or denied. Supporting documentation must be attached. See the reverse side of this form for more detailed Claim Filing directions.

Date(s) of Service	Name of Person Receiving Service	Name of Provider of Service	Type of Service/ Supply Provided	Reimbursement Requested
- - to - -				\$
- - to - -				\$
- - to - -				\$
- - to - -				\$
- - to - -				\$
- - to - -				\$
			TOTAL	\$

SECTION C – Account Holder Signature

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify as valid medical expenses according to my Summary Plan Description. These expenses have not been reimbursed and I will not seek reimbursement under my medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan or a flexible spending account plan. I understand that the expense for which I am reimbursed may not be used to claim any Federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me).

ACCOUNT HOLDER SIGNATURE	DATE

RETURN THIS FORM TO: SelectAccount
P.O. Box 64193
St. Paul, MN 55164-0193
FAX: 651-662-7247
1-866-231-0214

FORMS AVAILABLE:
www.selectaccount.com
or by calling
SelectAccount Customer Service

CUSTOMER SERVICE:
651-662-5065
1-800-859-2144
7 am - 7 pm, M-F