BENEFIT SERVICES BSG GROUP

CLAIM FORM

*my*SourceCard® Debit Card Substantiation Request Form

******Attach all RECEIPTS/EOB's And Fax To 315-779-9925******

Employer Name:	**TOWN OF CLAYTON**			
Employee Name:	Last / First / Mi		**SS#:**	
Employee Address:	Street / City / State / ZIP		**PHONE:**	( )
Email Address:				

☐ Please check if this is a new address

Please read the Reimbursement Account Rules and Claim Filing Instructions provided online before completing this claim.

* Information below must be FULLY completed

MEDICAL EXPENSE CLAIMS/DEPENDENT CARE CLAIMS

*my*SourceCard® Transaction	Type of Claim (HRA)	Dates of Service	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
☐ Yes ☐ No	HRA						$
☐ Yes ☐ No	HRA						$
☐ Yes ☐ No	HRA						$
☐ Yes ☐ No	HRA						$
☐ Yes ☐ No	HRA						$
☐ Yes ☐ No	HRA						$
☐ Yes ☐ No	HRA						$
☐ Yes ☐ No	HRA						$
						Total:	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement indicated on this substantiation form were incurred by me (and/or my spouse and/or eligible dependents), and were not reimbursed by any other plan nor will I seek reimbursement from any other source. To the best of my knowledge and belief, the expenses are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____/_____/_____

FOR FASTEST PROCESSING, FAX TO: 315-779-9925

Benefit Services Group
P.O. Box 6147
Watertown, NY 13601315-786-0201 or 800-471-4767