

## HEALTH CARE SPENDING ACCOUNT Claim for Reimbursement

EMPLOYEE NAME			SOCIAL SECURITY NUMBER				
EMPLOYEE ADDRESS			STREET		СПҮ		
			ZIP	PHONE NO:			
HEALTH CARE	EXPENSES	<u> </u>			•		
PATIENT NAME	DATES OF SERVICE		PROVIDER OF SERVICE	(A) TOTAL CHARGE	(B) AMOUNT PAID BY OTHER	(A-B) AMOUNT TO BE	
	FROM	то			SOURCES	REIMBURSED	
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