Request for Reimbursement

Mail, fax or upload completed form and receipts to BPAS at:
820 Gessner, Suite 1225, Houston, Texas 77024
Fax: (866) 254-2942 | bpas.com

Did you know you can skip the paperwork and request reimbursement online? Just log into your account at u.bpas.com. **It's fast and easy!**

1. PARTICIPANT INFORMATION

LAST NAME | FIRST NAME | MI | Social Security No. (SSN) or Secondary ID # (**REQUIRED**)

MAILING ADDRESS | ☐ Check here if new address | CITY | STATE | ZIP

DATE OF BIRTH | E-MAIL ADDRESS (home or personal recommended) ☐ Check here if new email address | AREA CODE and PHONE #

EMPLOYER NAME

2. EXPENSES

☐ Reimbursement ☐ Debit Card Substantiation

Under Benefit Type, enter one of the following benefit codes for each expense:
Health FSA: **HFSA** Limited Health FSA: **LHFSA** Dependent Care FSA: **DFSA*** Parking: **PRKG**

Date(s) Service Received	Service Provider/Merchant	Patient/ Dependent Name	Patient/ Dependent Birthdate	Description of Service(s)	Benefit Type	Amount
						$
						$
						$
						$
						$
						$
						$
	Medical Mileage *(Transportation for medical care. For current rates, visit www.irs.gov/Tax-Professionals/Standard-Mileage-Rates)*				HFSA	$
					Claim Total	

*Name of Qualified Dependent Care Provider:_____

*Dependent Care Provider Signature _____ Date:_____

3. PARTICIPANT SIGNATURE

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement under my 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. Where indicated, parking amounts claimed are without an available receipt and this certification includes such expenses.

REMEMBER: You must include an itemized receipt for each expense! All documentation must include the name and address of the service provider, the name of the person to whom the service(s) was rendered, description of the service(s), the date the service(s) was/were provided, and the dollar amount for the service(s). Cancelled checks are not eligible to be used as substantiation.

X_____
Participant Signature *Date*