



HCID-02



# HEALTH CARE FLEXIBLE SPENDING ACCOUNT CLAIM REIMBURSEMENT FORM

## How To Prepare Your Claim Form

**Step 1** Complete all employee information. This form will be processed electronically. Print clearly and only in the spaces provided.

**Step 2** Complete expense information. If the expense was incurred for an eligible dependent, indicate type of relationship in the box on the dependent name line. Use "C" for child, "S" for spouse or "O" for other.

**Step 3** Sign and date the claim form and attach proof of expense. Bills, statements, or "Explanation of Benefits" (EOBS) from medical plan(s) are required proof expense(s). Canceled checks are not sufficient evidence as proof of expense.

**IMPORTANT! DO NOT** combine multiple expenses on a single line. List each expense separately. Whether submitting single or multiple claims via fax, always send the claim form followed by its supporting documentation or receipts. Retain a copy for your records. **DO NOT** include fax cover sheet when faxing your reimbursement request.

## Employee Information

(PLEASE PRINT)

Please check this box if any of your information has changed

Name

Employer Name **Enterprise Holdings**

Address

Email Address

(By providing your email address, you will receive electronic notifications)

City

State

Zip

Daytime Phone #

Alternate ID

Grid for Alternate ID

Instructions: Please use blue or black ink and print like this



Grid for digits 0-9

## Expense Information

Start Date of Service			Note: Please report <u>only one</u> expense per block. Combining multiple expenses to one block may result in a delayed reimbursement.	Amount		
MONTH	DAY	YEAR		DOLLARS	CENTS	
NAME OF PROVIDER			TYPE OF SERVICE		DOLLARS	CENTS
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
NAME OF PROVIDER			TYPE OF SERVICE			
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
NAME OF PROVIDER			TYPE OF SERVICE		DOLLARS	CENTS
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
NAME OF PROVIDER			TYPE OF SERVICE			
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
NAME OF PROVIDER			TYPE OF SERVICE		DOLLARS	CENTS
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
NAME OF PROVIDER			TYPE OF SERVICE			
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
NAME OF PROVIDER			TYPE OF SERVICE		DOLLARS	CENTS
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
NAME OF PROVIDER			TYPE OF SERVICE			
DEPENDENT NAME			RELATIONSHIP TO EMPLOYEE			
To Submit Your Claim: Fax to: (866) 392-4090 (Toll-free) or (678) 762-5900 (Do Not Attach Fax Cover Sheet) Or mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853 Questions and information: Call (800) 550-0720 or visit <a href="http://www.flexdiret.adp.com/erac/">www.flexdiret.adp.com/erac/</a>			Total Expenses		DOLLARS	CENTS

## Certification

I certify that the expenses listed above qualify for reimbursement and have been incurred by me or by eligible members of my family. These expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Additionally, these expenses are not being claimed as tax deductions under Section 213 of the IRS code. Bills, statements, or other proof of the expenses are attached.

SIGNATURE

DATE