FSA Healthcare Reimbursement Claim Form

PITTMAN & ASSOCIATES, INC.

EMPLOYEE INFORMATION *(Please Print)*: ☐ Check here if address has changed

Name: _____ **SSN:** _____

Address: _____ **Day Phone:** _____

City, State, Zip: _____ **email address:** _____

Employer: **CUMBERLAND HEIGHTS FOUNDATIONS, INC.** **Group Number:** **HRA954**

UNREIMBURSED HEALTHCARE EXPENSES *(Attach supporting documentation)*

Proper Documentation should include the following information:
☐ Name of Patient ☐ Service Provided
☐ Provider's Name and Address ☐ Amount Billed
☐ Date(s) of Service ☐ Explanation of Benefits (preferred)

Name of Patient	Date(s) of Service	Name of Service Provider	Description of Services	Amount
		Total Unreimbursed Healthcare Expense		**$**

Contact your Benefits Representative if you have questions.
Benefits Administrator for Cumberland Heights Foundation, Inc:

Susan Newkirk
The Crichton Group
(615) 687-2840 phone / snewkirk@cbjw.net

Read Carefully:

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health care plan coverage. The undersigned fully understands that he or she alone is responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed or a proper expense which was incurred during the current plan year, the undersigned may be liable for payment of all related expenses including federal, state, or city income tax on amounts paid from the Plan which relate to such expenses.

Employee's Signature _____ Date: _____

MAIL or FAX to (901) 473-3266
Pittman & Associates, Inc. / Attn: HRA/FSA Department / P.O. Box 111047 / Memphis, Tennessee 38111