FSA/HRA MILEAGE REIMBUREMENT CLAIM FORM

This form is to be used to claim for reimbursement of medical expenses for travel to and from your medical care provider.
Please read these instructions before completing the claim form:

1. Employee must complete Part I and Part II.
2. Instructions for Part II "Medical Mileage Reimbursement":
   A. Use the chart below as your documentation indicating the number of miles traveled, date(s) of service, type of service and the provider's name and address.
   B. You may also print an use an map as your statement as long as it also includes the number of miles traveled, date(s) of service, type of service, and the provider's name and address.
3. Read the Employee Statement, sign and date the form.
4. Mail (or fax) the completed form to the address (or fax number) provided on this form. (Be sure that any necessary documentation is attached to the claim form).

Part I: Employee Information (Please Print)

EmployER Name:	**Plan:** ☐ **Flexible Spending Arrangement (FSA)** ☐ **Health Reimbursement Arrangement (HRA)**
Employee Name:	**Last 4 Digits of Social Security Number:**
Address:	**New Address?** ☐ **YES** ☐ **NO**
Daytime Phone	**Evening Phone**

Part II: Medical Mileage Expenses (Please Print)

The mileage rate is determined by the IRS. The 2017 mileage rate is 17 cents per mile. The 2018 Mileage rate is 18 cents per mile.

Date	Provider Name & Address	Type of Service (Medical, Dental, Vision, Prescription)	Number of miles traveled	Mileage Rate	Amount Claimed
				Total Amount Claimed	

Employee Statement:
I request payment from my reimbursement account for the expenses itemized on this claim form. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I further certify that I have met all requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature: _____ **Date:** _____

Send completed claim form to:

Health Economics Group, Inc.
1050 University Avenue, Suite A
Rochester, NY 14607
flex@heginc.com

(585) 241-9500, ext. 504
(800) 666-6690, ext. 504
FAX: (585) 241-9518