



# 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](http://bpas.com)



**Did you know you can skip the paperwork and request reimbursement online?** Just log into your account at [bpas.com](http://bpas.com). It's fast and easy!

**Need help? Call us toll free at 1-866-401-5272**

## 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

Under Benefit Type, enter one of the following benefit codes for each expense:

Health FSA: **HFSA**

Limited Health FSA: **LHFSA**

Dependent Care FSA: **DFSA\***

Mass Transit: **TRNS**

Parking: **PRKG**

Date(s) Service Received	Service Provider/Merchant	Patient/Dependent Name	Patient/Dependent Birthdate	Description of Service(s)	Benefit Type	Recurring Expense	Paid with BennyCard	Amount
						<input type="checkbox"/>	<input type="checkbox"/>	\$
						<input type="checkbox"/>	<input type="checkbox"/>	\$
						<input type="checkbox"/>	<input type="checkbox"/>	\$
						<input type="checkbox"/>	<input type="checkbox"/>	\$
						<input type="checkbox"/>	<input type="checkbox"/>	\$
	Medical Mileage (Transportation for medical care. For current rates, visit <a href="http://www.irs.gov/Tax-Professionals/Standard-Mileage-Rates">www.irs.gov/Tax-Professionals/Standard-Mileage-Rates</a> )				HFSA			\$
<b>Claim TOTAL</b>								\$

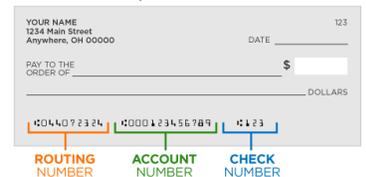
\*Name of Qualified Dependent Care Provider: \_\_\_\_\_

\*Dependent Care Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

## 4. DIRECT DEPOSIT AUTHORIZATION

I authorize BPAS to initiate credit/debit entries at the Depository named below. This authority will remain in full force and effect until BPAS has received written notification from the account signatory in such time and manner as to afford BPAS and Depository a reasonable time to act upon it.

Exact Name on Account	_____
Bank Name	_____
Transit Routing Number	_____
Account Number	_____
Account Type	<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account



## 5. 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.

X \_\_\_\_\_  
Participant Signature Date

**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.